FAMILY CARE of the Fox Cities

NAME _____ **DOB**_____

APPT WITH DR_____ **VISIT DATE**_____

REVIEW OF SYMPTOMS

DO YOU HAVE ANY RECENT OR ONGOING SYMPTOMS LISTED BELOW:

Constitutional Symptoms: Yes/No/NA (not applicable)

Are you in good health.....___/__/___
Fatigue.....___/__/___
Recent fever .....___/__/___
Chills .....___/__/___
Night sweats.....___/__/___
Recent weight change .....___/__/___
Other .....___/__/___

Eyes:

Wear contacts or glasses .....___/__/___
Eye pain .....___/__/___
Redness .....___/__/___
Discharge .....___/__/___
Loss or blurring of vision.....___/__/___
Double vision.....___/__/___
Other .....___/__/___

Ears, nose, mouth, throat:

Hearing loss .....___/__/___
Ringing in ears .....___/__/___
Ear pain .....___/__/___
Ear drainage .....___/__/___
Nasal obstruction/discharge .....___/__/___
Sinusitis.....___/__/___
Snoring.....___/__/___
Nosebleeds .....___/__/___
Tooth or gum problems.....___/__/___
Sore tongue or mouth sores.....___/__/___
Sore throat.....___/__/___
Hoarseness .....___/__/___
Difficult swallowing .....___/__/___
Other .....___/__/___

Cardiovascular: Yes/No/NA

Chest pain or pressure ___/__/___
Heart racing, skipping or irregular ___/__/___
Angina ___/__/___
Blood pressures running high ___/__/___
Blackouts, faints or loss of consciousness ___/__/___
Shortness of breath at night ___/__/___
Difficulty walking two blocks due to leg pain ___/__/___
Swelling in ankles or feet ___/__/___
Other ___/__/___

Respiratory:

Difficulty breathing ___/__/___
Wheezing ___/__/___
Coughing at night ___/__/___
Cough (persistent) ___/__/___
Sputum production ___/__/___
Coughing or spitting up blood ___/__/___
Other ___/__/___

Gastrointestinal:

Cramping or abdominal pain ___/__/___
Nausea ___/__/___
Heartburn or indigestion ___/__/___
Vomiting ___/__/___
Vomiting of blood ___/__/___
Frequent diarrhea ___/__/___
Painful bowel movements ___/__/___
Constipation ___/__/___
Blood in stool or black stools ___/__/___
Hemorrhoids or piles ___/__/___
Other ___/__/___

Male Genitourinary:

Burning or painful urination ___/__/___
Frequent urination ___/__/___
Leakage of urination ___/__/___
Blood in urine ___/__/___
Change in urine stream ___/__/___
Difficulty in emptying bladder ___/__/___
Night time urination ___/__/___
Bedwetting ___/__/___
Discharge from penis ___/__/___
Testicular pain or swelling ___/__/___

Problems with sexual function.....___/__/___
Other .....___/__/___

Female Genitourinary: Yes/No/NA
When was the first day of your last menstrual period .....___/__/___
Burning or painful urination .....___/__/___
Frequent urination.....___/__/___
Leakage of urine .....___/__/___
Urinary urgency .....___/__/___
Blood in urine .....___/__/___
Night time urination.....___/__/___
Vaginal itching.....___/__/___
Vaginal discharge.....___/__/___
Abnormal periods.....___/__/___
Painful periods .....___/__/___
Spotting between periods.....___/__/___
Hot flashes or flushes.....___/__/___
Vaginal bleeding since menopause.....___/__/___
Painful sexual activity.....___/__/___
Pelvic pain.....___/__/___
Breast lumps or nipple discharge.....___/__/___
Other .....___/__/___

Musculoskeletal:
Neck pain .....___/__/___
Back pain .....___/__/___
Muscle pain.....___/__/___
Joint pain and swelling.....___/__/___
Other .....___/__/___

Skin:
Skin rashes .....___/__/___
Lumps, bumps or moles you are concerned with .....___/__/___
Changes in hair .....___/__/___

Neurological:
Headache.....___/__/___
Localized or persistent weakness.....___/__/___
Generalized weakness.....___/__/___
Persistent tingling or numbness .....___/__/___
Seizures.....___/__/___
Tremors.....___/__/___
Dizziness.....___/__/___

Psychiatric: Yes/No/NA

Anxiety or excessive worry .....___/__/___
Appetite disturbance .....___/__/___
Sleep disturbance .....___/__/___
Difficulty concentrating .....___/__/___
Memory problems .....___/__/___
Moodiness or irritability .....___/__/___
Low self esteem .....___/__/___
Hopelessness .....___/__/___
Depression.....___/__/___
Suicidal thoughts or attempts.....___/__/___
Obsessive thoughts or compulsions .....___/__/___
Disturbing thoughts or feelings.....___/__/___
Attention deficit disorder .....___/__/___
Other .....___/__/___

Endocrine:

Increased thirst .....___/__/___
Heat or cold intolerance .....___/__/___
Increased appetite and eating .....___/__/___
Excessive sweating .....___/__/___
Other .....___/__/___

Hematologic/Lymphatic:

Abnormal bruising or bleeding .....___/__/___
Other .....___/__/___

Allergic/Immunologic:

Itchy eyes .....___/__/___
Itchy nose .....___/__/___
Frequent sneezing .....___/__/___
Hives .....___/__/___
Other .....___/__/___