Please check symptoms that apply to you currently or on a chronic basis:

Name **Date of Birth** **MRN #**

General Symptoms	Yes	No
Activity Change		
Appetite Change		
Chills		
Chronic Pain		
Daytime Sleepiness		
Sweating		
Fatigue		
Fever		
Unexpected Weight Change		
HENT	**Yes**	**No**
Congestion		
Dental Problem		
Drooling		
Ear Discharge		
Ear Pain or Facial Swelling		
Hearing Loss		
Mouth Sores		
Nosebleeds		
Postnasal Drip		
Reflux		
Runny Nose		
Sinus Pain		
Sinus Pressure		
Sneezing		
Snoring		
Sore Throat		
Ringing in Ears		
Trouble Swallowing		
Voice Change		
Eyes	**Yes**	**No**
Eye Discharge		
Eye Itching		
Eye Pain		
Eye Redness		
Light Sensitive		
Visual Disturbance		
Respiratory	**Yes**	**No**
Apnea		
Chest Tightness		
Choking		
Shortness of Breath		
Stridor		
Wheezing		

Cardiovascular	Yes	No
Chest Pain		
Leg Swelling		
Palpitations		
GI	**Yes**	**No**
Abdominal Distention		
Abdominal Pain		
Rectal Bleeding		
Blood in Stool		
Bowel Incontinence		
Constipation		
Diarrhea		
Nausea		
Rectal Pain		
Vomiting		
Endocrine	**Yes**	**No**
Cold Intolerance		
Heat Intolerance		
Excessive Thirst		
Frequent Hunger		
Frequent Urination		
GU	**Yes**	**No**
Bladder Incontinence		
Breast Lump		
Decreased Libido		
Difficulty Urinating		
Painful Intercourse		
Painful Urination		
Flank Pain		
Frequency		
Genital Sore		
Blood in Urine		
Wake Up at Night to Urinate		
Sexual Difficulties		
Urgency		
Urine Decreased		
MEN ONLY		
Erectile Dysfunction		
Penile Discharge		
Penile Pain		
Penile Swelling		
Scrotal Swelling		
Testicular Pain		
FEMALE ONLY		
Menstrual Change		
Menstrual Problem		
Pelvic Pain		
Vaginal Bleeding		
Vaginal Discharge		
Vaginal Pain		

Musculature	Yes	No
Joint Pain		
Back Pain		
Gait Problem		
Joint Swelling		
Muscle Pain		
Neck Pain		
Neck Stiffness		
Skin	**Yes**	**No**
Color Change		
Hair Change		
Hair Loss		
Nail Change		
Pale Appearance		
Rash		
Skin Change		
Skin Lesion		
Wound		
Allergy/Immuno	**Yes**	**No**
Environmental Allergies		
Food Allergies		
Immunocompromised		
Neurological	**Yes**	**No**
Dizziness		
Facial Asymmetry		
Headaches		
Light-Headedness		
Numbness		
Seizures		
Speech Difficulty		
Syncope (Pass Out)		
Tremors		
Weakness		
Hematologic	**Yes**	**No**
Enlarged Lymph Nodes		
Bruise Easily		
Psychiatric	**Yes**	**No**
Agitation		
Behavior Problem		
Confusion		
Decreased Concentration		
Depressed Mood		
Uneasy Mood		
Hallucinations		
Hyperactive		
Nervous/Anxious		
Self-Injury		
Severe Stress		
Sleep Disturbance		
Suicidal Ideas		

*** If you are a returning patient please fill out back of form ***