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

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

General Symptoms	Yes	No	Head & Neck	Yes	No	Respiratory	Yes	No	Gastrointestinal	Yes	No
Activity Change			Ear discharge			Cough			Acid Reflux		
Appetite Change			Ear Pain			Shortness of Breath			Swallowing Problems		
Chills			Facial swelling			Coughing up blood			Abdominal Pain		
Chronic Pain			Hearing Loss			Sleep Apnea			Poor Appetite		
Daytime Sleepiness			Ringing in ears			Tightness Across Chest			Bloating		
Sweating			Vertigo			Wheezing			Red Blood in Vomit		
Fatigue			Congestion						Black Color in Vomit		
Fever			Nose Bleeds			**Cardiovascular**	**Yes**	**No**	Fullness w/little food		
Unexpected Wt Change			Post Nasal Drip			Chest Pain			Heartburn		
			Runny Nose			Short of Breath on Exertion			Nausea		
Endocrine	**Yes**	**No**	Sinus Pain			Near-Fainting			Vomiting		
Cold Intolerance			Sneezing			Short of Breath Lying Flat			Bowel Habit Change		
Heat Intolerance			Snoring			Palpitations			Constipation		
Excessive Thirst			Dental Problems			Waking up Short of Breath			Diarrhea		
Frequent Hunger			Mouth Sores			Leg pain w/walking			Fecal Incontinence		
Frequent Urination			Sore Throat			Blue Fingers/toes			Excessive Gas		
			Choking			Lower Leg Swelling			Passing Bright Red Blood		
Allergy/Immuno			Hoarse Voice						Blood in Stool		
Environmental Allergies			Neck Stiffness			**Skin**	**Yes**	**No**	Rectal Pain		
Food Allergies						Abnormal Color Change					
Immunocompromised			**Eyes**	**Yes**	**No**	Dryness			**Genitourinary**	**Yes**	**No**
Recurrent Infections			Discharge			Flushing			Painful Urination		
Hives			Itching			Hair Change			Bedwetting		
			Pain			Itching			Flank pain		
Heme/Lymph			Redness			Nail Changes			Frequency		
Adenopathy			Blurriness			Rash			Blood in Urine		
Bleeding easily			Double Vision			Skin Lesion			Hesitancy		
Bruising easily			Halos			Skin Nodule			Incontinence		
			Light sensitivity			Wound Healing Issues			Waking up to Urinate		
Psychiatric	**Yes**	**No**	Loss of Vision						Reduced Urine Output		
Agitation			Visual Disturbance			**Musculoskeletal**	**Yes**	**No**	Retention		
Anxious / Nervous						Joint Pain			Urgency		
Behavior Problem			**Neurological**	**Yes**	**No**	Back Pain			Decreased libido		
Confusion			Balance issues			Gait Problem			Painful Intercourse		
Depressed Mood			Coordination issues			Joint Swelling			Genital Lesion		
Hallucinations			Dizziness			Muscle Cramps			Pelvic Pain		
High Stress Level			Loss of Speech			Muscle Fatigue			Bleeding after Intercourse		
Hyperactive			Facial Asymmetry			Neck Pain			Sexual difficulities		
Injury to self			Muscle Weakness			Stiff Joints			Vaginal Discharge		
Memory loss			Headaches						Vaginal Dryness		
Sleep Problems			Light-Headedness			**Breast**	**Yes**	**No**	No Menstral Cycle		
Suicidal thoughts			Numbness			Breast Lump or Mass			Painful Menses		
Trouble concentrating			Paralysis			Discharge			Heavy Menstral Cycle		
Violent thoughts			Paresthesias			Skin Change			Prolonged Menses		
			Seizures						Non-Menstrual Bleeding		
			Syncope						Other Menstrual Changes		
			Tremors								