Patient Name_____________________________________**Date**__________

Do you *currently* have any of the following symptoms? Please *Circle if YES*

General:
Fevers
Chills
Sweats
Loss of appetite
Fatigue
Insomnia
Weight loss
Weight gain

Respiratory:
Cough
Shortness of breath at rest
Excessive sputum
Coughing blood
Wheezing

Genitourinary:
Incontinence
Painful urination
Urinary frequency
Bloody urine
Night time urination

Musculoskeletal:
Back pain
Joint pain
Joint swelling
Muscle cramps
Muscle weakness
Muscle stiffness
Arthritis

Ears/Nose/Throat:
Painful swallowing
Earache
Ear discharge
Ear ringing
Decreased hearing
Nasal congestion
Nosebleeds
Sore throat
Hoarseness

Cardiovascular:
Chest pain with activity
Palpitations or fluttering
Loss of consciousness
Shortness of breath with activity
Shortness of breath when lying flat
Awakening short of breath
Leg swelling
Leg cramps when walking

Gastrointestinal:
Nausea
Vomiting
Diarrhea
Constipation
Abdominal pain
Black stool
Bloody stool

Endocrine:
Cold intolerance
Heat intolerance
Excessive thirst
Excessive urination
Excessive desire to eat
Weight change

Heme/Lymphatic:
Abnormal bruising
Abnormal bleeding
Enlarged lymph nodes

Allergic/Immunologic:
Itchy skin
Hay fever
Persistent Infections
HIV exposure

Neurological:
Weakness
Headaches
Numbness
Seizures
Tremors
Spinning sensation
Transient Paralysis

Skin:
Rash
Itching
Dryness
Suspicious lesions

Physicians Signature: ___________________

Date: ________________