Patient Name: _____

Please circle all CURRENT symptoms

General Health **All Normal**
Fever
Chills
Change in appetite
Lack of energy
Unexplained weight loss/weight gain

Ophthalmologic **All Normal**
Vision changes
Blurred vision

ENT **All Normal**
Sore throat
Sinus pain
Hoarseness
Swollen glands
Difficulty swallowing

Endocrinology (Glands) **All Normal**
Intolerance to heat or cold
Weakness

RESP (LUNGS & BREATHING) **All Normal**
Cough
Shortness of breath
Wheezing

Cardiovascular **All Normal**
Chest pain
Palpitations

GI (Stomach and Intestines) **All Normal**
Nausea
Vomiting
Diarrhea
Abdominal pain

(MUSCLES BONES & JOINTS) **All Normal**
Radiating leg pain
Loss of bowel/bladder control
Radiating arm pain
Numbness/tingling
Lower extremity weakness
Upper extremity weakness
Shoulder pain
Neck pain
Low back pain

Peripheral Vascular **All Normal**
Cold extremities
Decrease sensation in extremities

Integ (Skin Hair Breast) **All Normal**
Discoloration
Rash
Nail changes

Neurologic (brain and nerves) **All Normal**
Dizziness
Balance difficulty
Headache
Loss of strength
Loss of use of extremity

Psychiatric (Mood & Thinking) **All Normal**
Depressed mood
Feelings of depression
Anxiety
Difficulty sleeping