Patient name:________________________________ Date: ___/___/______

1. Please check the “Yes” or “No” box to indicate whether you have any of the following symptoms.
2. For any “Yes” responses, please check the “Current” box if this sympom relates to the reason for your visit today.

Constitutional			**NONE €**
	Yes	**No**	**Current**
Chills	€	€	€
Fever	€	€	€
Fatigue	€	€	€
Weight loss	€	€	€
Weight gain	€	€	€

Allergy/Immunology			**NONE €**
	Yes	**No**	**Current**
Itchy/red/watery eyes	€	€	€
Sneezing	€	€	€

Neurological			**NONE €**
	Yes	**No**	**Current**
Headaches	€	€	€
Numbness	€	€	€
Passing out	€	€	€

Eye			**NONE €**
	Yes	**No**	**Current**
Change in vision	€	€	€
Eye Pain	€	€	€

Ear, Nose, Mouth, Throat			**NONE €**
	Yes	**No**	**Current**
Hearing loss	€	€	€
Snoring problem	€	€	€
Sleep Disturbance	€	€	€

Respiratory			**NONE €**
	Yes	**No**	**Current**
Cough	€	€	€
Shortness of breath	€	€	€
Wheezing	€	€	€

Cardiovascular			**NONE €**
	Yes	**No**	**Current**
Chest pain	€	€	€
Shortness of breath	€	€	€
Sleep Disturbance	€	€	€

Reviewed by:

Gastrointestinal			**NONE €**
	Yes	**No**	**Current**
Difficulty swallowing	€	€	€
Abdominal pain	€	€	€
Heartburn	€	€	€
Rectal Bleeding	€	€	€
Diarrhea	€	€	€
Constipation	€	€	€

Genitourinary (M/F)			**NONE €**
	Yes	**No**	**Current**
Blood in the urine	€	€	€
Frequent urination	€	€	€

Date of last menstrual period: ___/___/_____

Hematologic/ Lymphatic			**NONE €**
	Yes	**No**	**Current**
Easy bruising or bleeding	€	€	€
Swollen lymph glands	€	€	€

Musculoskeletal			**NONE €**
	Yes	**No**	**Current**
Joint aches	€	€	€
Muscle aches	€	€	€

Skin			**NONE €**
	Yes	**No**	**Current**
Skin rash	€	€	€
Itching	€	€	€

Endocrine			**NONE €**
	Yes	**No**	**Current**
Feel cooler than others	€	€	€
Feel warmer than others	€	€	€
Excessive thirst	€	€	€

Psychiatric			**NONE €**
	Yes	**No**	**Current**
Depression	€	€	€
Anxiety	€	€	€

Other: