Patient name: _____ Date of birth: _____ Date of service: _____

Please review the symptoms listed below. Check all the symptoms **you have had in the last week** that pertain to today's visit. If your symptoms do not apply, please check the **"NONE"** box.

System	None	Recent Abnormal (for you) Symptoms
Constitutional	☐	☐ Change in appetite ☐ Chills ☐ Fatigue ☐ Fever ☐ Sweats ☐ Weight Loss
Cardiovascular	☐	☐ Chest Pain/Pressure ☐ Fainting ☐ Fluttering/Palpitations ☐ Leg Swelling
Neuro	☐	☐ Headache ☐ Light Headed ☐ Loss of Consciousness ☐ Numbness/Tingling ☐ Poor Balance ☐ Weakness
Psych	☐	☐ Anxiety/Nerves ☐ Depression ☐ Sleep Difficulties
Lymph	☐	☐ Easy Bleeding ☐ Frequent Infections ☐ Nodes/Glands
Eyes	☐	☐ Blurred Vision ☐ Contact Lenses/glasses ☐ Double Vision ☐ Eye Discharge ☐ Pain ☐ Eye Redness ☐ Eye Swelling
ENT	☐	☐ Difficulty Swallowing ☐ Dizziness ☐ Ear Pain ☐ Hoarseness ☐ Mouth Pain ☐ Nasal Congestion ☐ Nose Discharge ☐ Sore Throat
Respiratory	☐	☐ Congestion ☐ Cough ☐ Shortness of Breath ☐ Snoring ☐ Wheeze
GI	☐	☐ Abdominal Pain ☐ Blood in Stool ☐ Constipation ☐ Diarrhea ☐ Nausea ☐ Rectal/Perirectal Complaints ☐ Urinary/Bowel Changes ☐ Vomiting
GU	☐	☐ Blood in Urine ☐ Discharge ☐ Frequent Urination ☐ Nighttime Urination ☐ Painful Urination ☐ Sexual Difficulties
Muscular	☐	☐ Back Pain ☐ Joint Pain ☐ Muscle Pain ☐ Swelling
Skin	☐	☐ Bruising ☐ Itching ☐ Laceration ☐ Rash ☐ Redness ☐ Skin Sores
Endocrine	☐	☐ Abnormal Blood Sugar ☐ Cold Intolerance ☐ Excessive Hunger/Thirst ☐ Hair loss ☐ Heat Intolerance
Allery/ Immun.	☐	☐ Itchy Eyes ☐ Lip/Tongue/Throat Swelling ☐ Post Nasal Drip ☐ Sneezing

Patient/Guardian Signature: _____ Date: _____