

Print Patient Name	Date:	Pt ID#:	
Please check the appropriate boxes indicating the symptoms you are CURRENTLY experiencing.			
Constitutional	<input type="checkbox"/> Frequently Tired <input type="checkbox"/> Body Aches <input type="checkbox"/> Weight Gain	<input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Chills <input type="checkbox"/> Weight Loss <input type="checkbox"/> Swelling in Armpits or Groin
Eyes	<input type="checkbox"/> Discharge from Eye <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Do You Wear Contacts or Glasses?	<input type="checkbox"/> Eye Pain <input type="checkbox"/> Peripheral Vision Changes <input type="checkbox"/> Blind Spots	<input type="checkbox"/> Double Vision <input type="checkbox"/> Changes in Vision <input type="checkbox"/> Tearing
HENT	<input type="checkbox"/> Severe Headaches <input type="checkbox"/> Recent Head Injury <input type="checkbox"/> Nose Bleeding <input type="checkbox"/> Bleeding of Gums <input type="checkbox"/> Difficulty Hearing <input type="checkbox"/> Teeth Problems	<input type="checkbox"/> Dizziness <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Nasal Discharge <input type="checkbox"/> Neck Tenderness <input type="checkbox"/> Hear Buzzing <input type="checkbox"/> Dentures	<input type="checkbox"/> Lightheadedness <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Postnasal Drip <input type="checkbox"/> Sore Throat <input type="checkbox"/> Earaches
Breasts	<input type="checkbox"/> Lumps <input type="checkbox"/> Swelling	<input type="checkbox"/> Tenderness	<input type="checkbox"/> Nipple Discharge
Cardiovascular	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Shortness of Breath at Night (laying down) <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Tightness	<input type="checkbox"/> Irregular Heart Beats <input type="checkbox"/> Difficulty Breathing on Exertion <input type="checkbox"/> Lower Extremity Swelling <input type="checkbox"/> Limp in Walk <input type="checkbox"/> Heart Thumping/Racing	<input type="checkbox"/> Rapid Heart Rate <input type="checkbox"/> Discomfort Breathing - Lying <input type="checkbox"/> Bluish Color to Skin <input type="checkbox"/> Abnormal Sensation - Standing Fainting
Respiratory	<input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Hoarseness <input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing <input type="checkbox"/> Abnormal Sputum Production	<input type="checkbox"/> Phlegm <input type="checkbox"/> Coughing up blood
Gastrointestinal	<input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Vomiting Blood <input type="checkbox"/> Blood in Stools <input type="checkbox"/> Excessive Flatulence	<input type="checkbox"/> Vomiting <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Excessive Belching <input type="checkbox"/> Black Tarry Stool <input type="checkbox"/> Bloating	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Irregular Bowels
Genitourinary	<input type="checkbox"/> Urgency <input type="checkbox"/> Excessive Urination at Night <input type="checkbox"/> Difficulty Holding Urine <input type="checkbox"/> Difficult or Painful Intercourse <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Significant PMS <input type="checkbox"/> Heavy Flow <input type="checkbox"/> Breast Tenderness <input type="checkbox"/> Use Douches	<input type="checkbox"/> Frequency <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Urinary Retention <input type="checkbox"/> Genital Sores <input type="checkbox"/> Possible Pregnancy <input type="checkbox"/> Cramps <input type="checkbox"/> Headaches <input type="checkbox"/> Vaginal itching <input type="checkbox"/> Leaking urine	<input type="checkbox"/> Painful or Difficult Urination <input type="checkbox"/> Change in Urine Color <input type="checkbox"/> Decreased Libido <input type="checkbox"/> Irregular Menses <input type="checkbox"/> Abnormal Absence of Period <input type="checkbox"/> Mood Changes <input type="checkbox"/> Pelvic Pain <input type="checkbox"/> Yeasting <input type="checkbox"/> Difficult Starting Urine Flow
Skin	<input type="checkbox"/> Rash <input type="checkbox"/> Skin Dryness <input type="checkbox"/> New Skin Lesions	<input type="checkbox"/> Itching <input type="checkbox"/> Hair Growth Change <input type="checkbox"/> Changes to Existing Skin Lesions/ Moles	<input type="checkbox"/> Pigmentation Changes <input type="checkbox"/> Nail Changes
Neurologic	<input type="checkbox"/> Muscular Weakness <input type="checkbox"/> Difficulty Concentrating <input type="checkbox"/> Seizures	<input type="checkbox"/> Incoordination <input type="checkbox"/> Memory Difficulties <input type="checkbox"/> Tremors	<input type="checkbox"/> Tingling or Numbness <input type="checkbox"/> Speech Difficulties <input type="checkbox"/> Loss of Balance
Musculoskeletal	<input type="checkbox"/> Joint Pain <input type="checkbox"/> Limitation of Motion	<input type="checkbox"/> Joint Swelling <input type="checkbox"/> Muscular Weakness	<input type="checkbox"/> Muscle Pain <input type="checkbox"/> Back Pain
Endocrine	<input type="checkbox"/> Excessive Urination <input type="checkbox"/> Loss of Hair <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Weight Gain	<input type="checkbox"/> Excessive or Abnormal Thirst <input type="checkbox"/> Constipation <input type="checkbox"/> Decreased Libido <input type="checkbox"/> Weight Loss	<input type="checkbox"/> Excessive Breast Milk <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Central Obesity <input type="checkbox"/> Acne
Psychiatric	<input type="checkbox"/> Anxiety <input type="checkbox"/> Feeling Confused <input type="checkbox"/> Suicidal Ideation <input type="checkbox"/> I Have No Energy <input type="checkbox"/> I Feel Sluggish/Restless	<input type="checkbox"/> Depression <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Excessive Anger <input type="checkbox"/> Sleeping Too Much <input type="checkbox"/> I Feel Helpless About Future	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Compulsive Behaviors <input type="checkbox"/> I Feel Unhappy <input type="checkbox"/> Sleeping Too Little
Heme-Lymph	<input type="checkbox"/> Lightheadedness <input type="checkbox"/> Purple Spots on Skin	<input type="checkbox"/> Easy Bleeding <input type="checkbox"/> Lymph Node Enlargement or Tenderness	<input type="checkbox"/> Easy Bruising
Allergic-Immunologic	<input type="checkbox"/> Sinus Allergy Symptoms	<input type="checkbox"/> Allergic Skin Inflammation	<input type="checkbox"/> Frequent Illnesses

Layman's Terms	Spanish Terms
Constitutional	
Tired	Fatiga/Cansancio
Fever	Temperatura/Fiebre
Chills	Estremecimiento/Escalofrios
Body Aches	Dolor del Cuerpo
Night Sweats	Sudor Nocturno/Sudar por la Noche
Weight Loss	Perdida de Peso
Weight Gain	Aumento de Peso
Loss of Appetite	Perdida de Apetito
Eyes	
Discharge from Eye	Descarga del Ojo
Eye Pain	Dolor del Ojo
Double Vision	Vision Doble
Blurred Vision	Vision Borrosa/Empanada
Peripheral Vision Changes	Cambio de Vision Periferico
Changes in Vision	Cambio de Vision
HENT	
Headaches	Dolor de Cabeza
Dizziness	Vertigo/Marcado/Aturdido
Lightheadedness	Mareos
Recent Head Injury	Reciente Herida/Lesion en la Cabeza
Sinus Pain	Dolor de Sinusitis
Nasal Congestion	Congestion Nasal
Nose Bleeding	Sangrar del Nariz
Nasal Discharge	Descarga Nasal
Postnasal Drip	
Bleeding of Gums	Sangramiento de la Encia
Neck Tenderness	Cuello Adolorido
Sore Throat	Dolor de la Garganta
Breasts	
Lumps	Masa en el Seno
Tenderness	Senos Adoloridos
Swelling	Inflamacion de los Senos
Nipple Discharge	Descarga del Pezon
Cardiovascular	
Chest Pain	Dolor del Pecho
Irregular Heart Beats	Irregularidad del latido del Corazon
Rapid Heart Rate	Ritmo Rapido del Corazon
Loss of Consciousness	Perdida de la Consciencia
Difficulty Breathing on Exertion	Dificultad al Respirar con esfuerzo
Discomfort in Breathing while Lying Down	Incomodidad al Respirar Mientras este Acostado
Shortness of Breath at Night (laying down)	
Lower Extremity Swelling	Inflamacion de Extremidades Inferiores
Bluish Color to Skin	Piel Azul
Varicose Veins	Venas Vericosas
Limp in Walk	Cojear al Caminar
Abnormal Sensations while Standing	Sensaciones Anormales Cuando Esta Parado
Respiratory	
Shortness of Breath	Respiraciones Cortas
Wheezing	Resollar
Cough	Toser
Hoarseness	Afonico
Abnormal Sputum Production	Produccion Anormal de Saliva
Gastrointestinal	
Nausea	Nausea
Vomiting	Vomitos
Diarrhea	Diarrea
Constipation	Estrenimiento
Difficulty Swallowing	Dificultad Para Tragar
Heartburn	Acidez
Vomiting Blood	Vomitar Sangre
Excessive Belching	Eructar Excesivamente
Abdominal pain	Dolor Abdominal
Blood in Stools	Sangre en el Excremento
	Sangre en el Vomito/Excremento Negro y ???
Black Tarry Stool	
Hemorrhoids	Hemorroides
Excessive Flatulence	Exceso de Gases
Genitourinary	
Urgency	Urgencia de Orinar
Frequency	Frecuencia de Orinar
Painful or Difficult Urination	Dolor al Orinar
Excessive Urination at Night	Orinar Excesivamente por la Noche
Blood in Urine	Sangre en la Orina
Change in Urine Color	Cambio de Color de la Orina
Difficulty Holding Urine	Incontinencia
Urinary Retention	Retencion de Orina
	Perdida del Apetito de tener Relaciones Sexuales
Decreased Libido	
Difficult or Painful Intercourse	Dolor al Tener Relaciones Sexuales
Genital Sores	Llagas Genitales
Irregular Menses	Menstruacion Irregular
Vaginal Discharge	Descarga Vaginal
Possible Pregnancy	Posible Embarazada
Abnormal Absence of Menstruation	Anormal Ausencia de Menstruacion
Significant PMS	Significado de PMS
Integument	
Rash	Salpullido
Itching	Picar
Pigmentation Changes	Cambio de Pigmentacion
Skin Dryness	Piel Seco
Hair Growth Change	Cambio del Crecimiento del Pelo
Nail Changes	Cambio de las Unas
New Skin Lesions	Lesiones Nuevas de la Piel
Changes to Existing Skin Lesions/ Moles	Cambios de Lunares Existente
Neurologic	
Muscular Weakness	Debilidad de los Musculos
Incoordination	Incoordinacion
Tingling or Numbness	Entumecimiento
Difficulty Concentrating	Dificultad al Concentrar
Memory Difficulties	Dificultades de Memoria
Speech Difficulties	Dificultad al Hablar
Seizures	Ataques
Tremors	Temblores
Loss of Balance	Perdida de Equilibrio
Musculoskeletal	
Joint Pain	Dolores del articulacion
Joint Swelling	Hinchazon del articulacion
Muscle Pain	Dolores Musculares
Limitation of Motion	Limitaciones de Movimiento
Muscular Weakness	Debilidad de los Musculos
Back Pain	Dolores de la Espalda
Endocrine	
Excessive Urination	Orinar Excesivamente
Excessive or Abnormal Thirst	Tener Sed Excesivamente
Excessive Flow of Milk from Breasts	Segregar Leche Excesivamente
Loss of Hair	Perida de Pelo
Constipation	Constipacion
Cold Intolerance	Intolerancia al Frio
Heat Intolerance	Intolerancia al Calor
	Perdida del Apetito de tener Relaciones Sexuales
Decreased Libido	
Central Obesity	Obesidad
Weight Gain	Aumento del Peso
Weight Loss	Perdida del Peso
Acne	Acne
Psychiatric	
Anxiety	Ansiedad
Depression	Depresion
Hallucinations	Alucinaciones
Feeling Confused	Sentimientos Confusos
Difficulty Sleeping	Dificultades al Dormir
Compulsive Behaviors	Conductas Compulsivos
Suicidal Ideation	Ideas Suicidas
Excessive Anger	Choler Excesivo
Heme-Lymph	
Lightheadedness	Mareos
Easy Bleeding	Sangrar Facilmente
Easy Bruising	Moretir Facilmente
Purple Spots on Skin	Manchas Moradas en la Piel
Lymph Node Enlargement or Tenderness	
Allergic-Immunologic	
Sinus Allergy Symptoms	Alergias
Allergic Skin Inflammation	Alergias de la Piel
Frequent Illnesses	Infermedades Frecuentes