

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"/> Fever | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Body Aches | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Swelling in Armpits or Groin |

Eyes

- | | | |
|---|--|--|
| <input type="checkbox"/> Discharge from Eye | <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Peripheral Vision Changes | <input type="checkbox"/> Changes in Vision |
| <input type="checkbox"/> Do You Wear Contacts or Glasses? | <input type="checkbox"/> Blind Spots | <input type="checkbox"/> Tearing |

HENT

- | | | |
|---|--|---|
| <input type="checkbox"/> Severe Headaches | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Lightheadedness |
| <input type="checkbox"/> Recent Head Injury | <input type="checkbox"/> Sinus Pain | <input type="checkbox"/> Nasal Congestion |
| <input type="checkbox"/> Nose Bleeding | <input type="checkbox"/> Nasal Discharge | <input type="checkbox"/> Postnasal Drip |
| <input type="checkbox"/> Bleeding of Gums | <input type="checkbox"/> Neck Tenderness | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Difficulty Hearing | <input type="checkbox"/> Hear Buzzing | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Dentures | |

Breasts

- | | | |
|-----------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Lumps | <input type="checkbox"/> Tenderness | <input type="checkbox"/> Nipple Discharge |
| <input type="checkbox"/> Swelling | | |

Cardiovascular

- | | | |
|---|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irregular Heart Beats | <input type="checkbox"/> Rapid Heart Rate |
| <input type="checkbox"/> Loss of Consciousness | <input type="checkbox"/> Difficulty Breathing on Exertion | <input type="checkbox"/> Discomfort Breathing - Lying |
| <input type="checkbox"/> Shortness of Breath at Night (Apnea) | <input type="checkbox"/> Lower Extremity Swelling | <input type="checkbox"/> Bluish Color to Skin |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Limp in Walk | <input type="checkbox"/> Abnormal Sensation - Standing Fainting |
| <input type="checkbox"/> Tightness | <input type="checkbox"/> Heart Thumping/Racing | |

Respiratory

- | | | |
|--|---|--|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Phlegm |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Abnormal Sputum Production | <input type="checkbox"/> Coughing up blood |
| <input type="checkbox"/> Cough | | |

Gastrointestinal

- | | | |
|---|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Vomiting Blood | <input type="checkbox"/> Excessive Belching | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Black Tarry Stool | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Excessive Flatulence | <input type="checkbox"/> Bloating | <input type="checkbox"/> Irregular Bowels |

Genitourinary

- | | | |
|---|---|---|
| <input type="checkbox"/> Urgency | <input type="checkbox"/> Frequency | <input type="checkbox"/> Painful or Difficult Urination |
| <input type="checkbox"/> Excessive Urination at Night | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Change in Urine Color |
| <input type="checkbox"/> Difficulty Holding Urine | <input type="checkbox"/> Urinary Retention | <input type="checkbox"/> Decreased Libido |
| <input type="checkbox"/> Difficult or Painful Intercourse | <input type="checkbox"/> Genital Sores | <input type="checkbox"/> Irregular Menses |
| <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Possible Pregnancy | <input type="checkbox"/> Abnormal Absence of Period |
| <input type="checkbox"/> Significant PMS | <input type="checkbox"/> Cramps | <input type="checkbox"/> Mood Changes |
| <input type="checkbox"/> Heavy Flow | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pelvic Pain |
| <input type="checkbox"/> Breast Tenderness | <input type="checkbox"/> Vaginal itching | <input type="checkbox"/> Yeasting |
| <input type="checkbox"/> Use Douches | <input type="checkbox"/> Leaking urine | <input type="checkbox"/> Difficult Starting Urine Flow |

Skin

- | | | |
|---|---|---|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Itching | <input type="checkbox"/> Pigmentation Changes |
| <input type="checkbox"/> Skin Dryness | <input type="checkbox"/> Hair Growth Change | <input type="checkbox"/> Nail Changes |
| <input type="checkbox"/> New Skin Lesions | <input type="checkbox"/> Changes to Existing Skin Lesions/Moles | |

Neurologic

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|---|--|---|
| <input type="checkbox"/> Muscular Weakness | <input type="checkbox"/> Incoordination | <input type="checkbox"/> Tingling or Numbness |
| <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Memory Difficulties | <input type="checkbox"/> Speech Difficulties |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Tremors | <input type="checkbox"/> Loss of Balance |

Musculoskeletal

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Muscle Pain |
| <input type="checkbox"/> Limitation of Motion | <input type="checkbox"/> Muscular Weakness | <input type="checkbox"/> Back Pain |

Endocrine

- | | | |
|--|---|--|
| <input type="checkbox"/> Excessive Urination | <input type="checkbox"/> Excessive or Abnormal Thirst | <input type="checkbox"/> Excessive Breast Milk |
| <input type="checkbox"/> Loss of Hair | <input type="checkbox"/> Constipation | <input type="checkbox"/> Cold Intolerance |
| <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Decreased Libido | <input type="checkbox"/> Central Obesity |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Acne |

Psychiatric

- | | | |
|---|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Feeling Confused | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Compulsive Behaviors |
| <input type="checkbox"/> Suicidal Ideation | <input type="checkbox"/> Excessive Anger | <input type="checkbox"/> I Feel Unhappy |
| <input type="checkbox"/> I Have No Energy | <input type="checkbox"/> Sleeping Too Much | <input type="checkbox"/> Sleeping Too Little |
| <input type="checkbox"/> I Feel Sluggish/Restless | <input type="checkbox"/> I Feel Helpless About Future | |

Heme-Lymph

- | | | |
|---|---|--|
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Easy Bleeding | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Purple Spots on Skin | <input type="checkbox"/> Lymph Node Enlargement or Tenderness | |

Allergic-Immunologic

- | | | |
|---|---|---|
| <input type="checkbox"/> Sinus Allergy Symptoms | <input type="checkbox"/> Allergic Skin Inflammation | <input type="checkbox"/> Frequent Illnesses |
|---|---|---|