

Date _____

Name _____

Pt. # _____

Please circle any of the following symptoms you have experienced in the **last month**:

Constitutional

Weight loss	Weight gain	Fever	Fatigue	Depression/Sadness
Severe anxiety	Difficulty sleeping	Headaches	Other	

Eyes

Vision changes	Glasses/Contacts	Other
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Ear/Nose/Throat

Sores	Drainage/Congestion	Headache	Hearing Loss	Other
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Cardiovascular

Difficulty breathing while lying on back	Difficulty breathing on exertion		
Chest Pain	Swelling	Palpitations	Other

Respiratory

Wheezing	Shortness of breath	Cough	Coughing up blood
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Gastrointestinal

Diarrhea	Constipation	Bloody Stool	Nausea/vomiting/indigestion
Flatulence (gas)	Pain	Fecal incontinence (loosing stool)	

Genitourinary

Blood in urine	Pain when urinating	Urinary Frequency	Urgency/can't hold urine
Incomplete emptying			
Vaginal dryness	Pain with sex	Hot flashes/flushes	
PMS	Abnormal vaginal bleeding	Vaginal discharge	
Abnormal or painful periods			

Musculoskeletal

Muscle weakness	Muscle or joint pain	Other
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Skin

Rash	Sores	Pigmented lesions	Dry skin	Other
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Breast

Breast pain	Discharge	Masses	Other
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Neurologic

Fainting spells	Seizures	Numbness	Trouble walking
Severe memory problems		Other	

Endocrine

Hot flashes	Hair loss	Heat/cold intolerance	Very thirsty	Other
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Other

Swollen lymph nodes	Bruises	Bleeding	Allergic reaction
Illness	Other		

Current Medications _____

Reason for visit _____

Allergies _____ **First Day of Last Period** _____