

Date _____ Name _____ DOB _____

Please select those symptoms you are currently experiencing regularly.

CONSTITUTIONAL SYMPTOMS

- Good general health
- Recent weight loss
- Excessive daytime sleepiness
- Snoring
- Fevers
- Fatigue
- Night sweats

EYES

- Double vision
- Blurred vision

EAR, NOSE, THROAT & MOUTH

- Ringing in the ears
- Difficulty hearing
- Chronic sinus drainage
- Frequent sneezing
- Swollen glands
- Change in voice (hoarseness)

PULMONARY

- Chronic cough
- Shortness of breath
- Wheezing
- Blood in sputum
- Pain with breathing

CARDIOVASCULAR

- Chest pains
- Palpitations (heart racing)
- Swelling of feet

GASTROINTESTINAL

- Heartburn
- Nausea or vomiting
- Poor appetite
- Change in bowel movements
- Diarrhea
- Constipation
- Blood in stool

NEUROLOGICAL

- Morning headaches
- Migraine Headaches
- Dizziness
- Seizures
- Poor memory
- Tremors
- Weakness

HEMATOLOGICAL/LYMPHATIC

- Easy bruising
- Excessive bleeding
- Enlarged gland/lymph nodes

MUSCULOSKELETAL

- Joint pains
- Joint stiffness
- Joint swelling
- Difficulty walking
- Back pain

GENITOURINARY

- Frequent urination
- Burning urination
- Urinary incontinence
- Blood in urine
- Males: Testicular pain
- Female: Vaginal discharge

INTEGUMENTARY (SKIN/BREASTS)

- Itching or rash
- Varicose veins
- Change in skin color
- Abnormality in nails/hair
- Breast pain
- Nipple discharge

PSYCHIATRIC

- Depression
- Mood swings
- Increased irritability
- Difficulty concentrating
- Nervousness/anxiety
- Insomnia

ENDOCRINE

- Excessive thirst
- Poor control of blood sugar
- Intolerance to heat
- Intolerance to cold

ALLERGIC/IMMUNOLOGIC

- Nasal allergies/hay fever
- Recurrent hives