Date_____ Name_____ DOB_____

Please select those symptoms you are currently experiencing regulary.

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