Name:_____ DOB:_____

PLEASE INDICATE IF YOU HAVE THE FOLLOWING

CONSTITUTIONAL
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss

HEENT
- ☐ Vision loss
- ☐ Blurred vision
- ☐ Dry mouth
- ☐ Dry eyes
- ☐ Eye pain
- ☐ Jaw pain
- ☐ Nasal sores
- ☐ Oral ulcers

PULMONARY
- ☐ Cough
- ☐ Cough up blood
- ☐ Shortness of breath
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Swelling of lower extremities
- ☐ Palpitations
- ☐ Hands/feet discolor with cold
- ☐ Varicose Veins

GASTROINTESTINAL
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting

GENITOURINARY
- ☐ Pain with urination
- ☐ Blood in the urine
- ☐ Kidney stones
- ☐ Urinary frequency
- ☐ Urinary incontinence

ENDOCRINE
- ☐ Cold intolerance
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Hot flashes
- ☐ Excessive thirst

NEUROLOGIC
- ☐ Dizziness
- ☐ Numbness of arms or legs
- ☐ Headaches
- ☐ Seizures
- ☐ Passing out episodes
- ☐ Tremors

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Insomnia

SKIN
- ☐ Hives
- ☐ Itching
- ☐ Nail changes
- ☐ Sensitivity to sunlight
- ☐ Psoriasis
- ☐ Rash

MUSCULOSKELETAL
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Morning stiffness
- ☐ Muscle pain
- ☐ Neck pain

HEMATOLOGIC/LYMPH
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Swollen lymph nodes
- ☐ Frequent infections