

Birth date/Name: _____

Review of Symptoms

Please ✓ following symptoms you have experienced within the last **SIX WEEKS.**

Date of 1st visit: _____
 Date of 2nd visit: _____
 Date of 3rd visit: _____
 Date of 4th visit: _____
 Date of 5th visit: _____

1	2	3	4	5	
					Eyes
					Trouble seeing
					Eye pain
					Enflamed eyes
					Double vision
					Wear glasses or contacts
					Cardiovascular
					Chest pain
					Swelling ankles
					Bluish fingers or lips
					High blood pressure
					Palpitations or irregularity
					Vein trouble
					Leg clots
					Lower leg pain when walking
					Respiratory
					Shortness of breath
					Wheezing
					Persistent cough
					Bloody sputum
					Genitourinary
					Unable to hold urine
					Pain or burning on urination
					Night time urination
					Blood in urine
					Vaginal discharge or malodor
					Pain or lump in testis
					Poor quality erections
					Pain with intercourse
					Disappointing sex life
					Problems with periods
					Skin
					Rash or dry skin
					Hives or itching
					Change in hair or nails
					Easy bruising
					Non-healing sore
					New or changed dark spot
					Nervous/Mental
					Headaches
					Dizziness or loss of balance
					Fainting
					Memory loss, poor concentration
					Change in sensation
					Weakness or numbness
					Poor coordination
					Mood swings
					Sleeplessness
					Nervousness, anxiety, fear
					Depression, grief or sadness
					Hard to find pleasure
					Family problems
					Occupational concerns
					Concerns with my alcohol use
					I wish to quit smoking

1	2	3	4	5	
					General
					Fatigue, tire easily
					Marked weight gain or loss
					Restlessness, being "hyper"
					Night sweats
					Persistent fever
					Ear, Nose, Throat & Neck
					Loss of hearing
					Ringing in ears
					Discharge from an ear
					Nasal obstruction
					Sore gums or tongue
					Dental problems
					Jaw pain
					Hoarseness
					Neck stiffness, swelling or pain
					Digestive
					Change in appetite
					Difficulty swallowing
					Heartburn
					Abdominal pain
					Swelling of/in abdomen
					Belching or excess gas
					Nausea or vomiting
					Vomiting blood
					Rectal bleeding or dark stools
					Constipation or diarrhea
					Hemorrhoids
					Any food intolerance
					Use of laxatives
					Purging or induced vomiting
					Binge eating or drinking
					Following a special diet
					Muscle/Skeletal
					Back or neck pain
					Muscle cramps or weakness
					Joint pain, swelling or stiffness
					Foot pain
					Breast/Chest
					Lump, pain, or discharge
					Endocrine
					Excess thirst
					Intolerance to heat or cold
					Suffering "hot flashes"
					Hematologic/Immunologic
					Lymph node swelling or pain
					Allergy symptoms
					Engaged in risky sex or drugs
					Any other concerns:
