Review of Symptoms

Patient Name: ____ DOB: ______________________

Patient EMR #: _________________________________

Please select below any problem you have experienced in the last three to six months.

GENERAL HEALTH PROBLEMS (CONSTITUTIONAL):

- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Malaise (feeling of being unwell)
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ None

EYE PROBLEMS PROBLEMS:

- ☐ Discharge from eye
- ☐ Eye pain
- ☐ Double vision
- ☐ Changes in vision
- ☐ Dryness
- ☐ Burning
- ☐ None

HEART OR CIRCULATION PROBLEMS (CARDIOVASCULAR):

- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Rapid heart rate
- ☐ None

LUNG OR RESPIRATORY PROBLEMS:

- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Coughing up blood
- ☐ None

STOMACH PROBLEMS (GASTROINTESTINAL):

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ None

SKIN (INTEGUMENT):

- ☐ Rash
- ☐ Itching
- ☐ New skin lesions
- ☐ Changes to existing skin lesions
- ☐ None

BRAIN OR NERVOUS SYSTEM PROBLEMS:

- ☐ Loss of coordination
- ☐ Tingling
- ☐ Numbness
- ☐ Seizures
- ☐ None

MUSCULOSKELETAL PROBLEMS:

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Limitation of motion
- ☐ Muscular weakness
- ☐ Back pain
- ☐ None

ENDOCRINE PROBLEMS:

- ☐ Frequent urination
- ☐ Excessive thirst
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ None

BLOOD OR LYMPH NODES PROBLEMS:

- ☐ Bleeding easily
- ☐ Bruising easily
- ☐ Node enlargement
- ☐ None

ALLERGY PROBLEMS:

- ☐ Sinus or allergy symptoms
- ☐ Frequent illness
- ☐ None