

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:

- 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) PROBLEMS:

- 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