

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: _____

				1	2	3	4	
								GI cont.
1	2	3	4					Constipation
								Diarrhea
								Hemorrhoids
								Any food intolerance
								Use of laxatives
								Purging or induced vomiting
								Binge eating or drinking
								Following special diet
								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
								Musculoskeletal
								Back pain
								Neck pain
								Muscle cramps or weakness
								Joint pain, swelling or stiffness
								Foot pain
								Skin
								Rash, hives
								Dry skin
								Itching
								Change in hair or nails
								Easy bruising
								Non-healing sore
								New or changed dark spot
								Neuro
								Headaches
								Dizziness or loss of balance
								Fainting
								Memory loss, poor concentration
								Change in sensation
								Weakness or numbness
								Poor coordination
								Psychiatric
								Mood swings
								Sleeplessness
								Nervousness, anxiety, fear
								Depression, grief or sadness
								Hard to find pleasure
								Family problems
								Occupational concerns
								Hematologic / Infectious
								Lymph node swelling or pain
								Engaged in risky sex or drugs
								Allergy
								Allergy symptoms
								Any other concerns:

1	2	3	4

General

Fatigue, tire easily
 Marked weight gain or loss
 Restlessness, being "hyper"
 Night sweats
 Persistent fever

1	2	3	4

Eyes

Trouble seeing
 Eye pain
 Inflamed eyes
 Double vision
 Wear glasses or contacts

1	2	3	4

ENT

Loss of hearing
 Ringing in ears
 Discharge from an ear
 Nasal obstruction
 Sore gums
 Sore tongue
 Dental problems
 Jaw pain
 Hoarseness
 Sinus symptoms

1	2	3	4

Endocrine

Excess thirst
 Intolerance to cold
 Intolerance to heat
 Suffering "hot flashes"

1	2	3	4

Breast / Chest

Lump, pain, or discharge

1	2	3	4

Cardiovascular

Chest pain
 Swelling ankles
 Bluish fingers or lips
 High blood pressure
 Palpitations or irregularity
 Vein trouble
 Leg clots
 Lower leg pain when walking

1	2	3	4

Respiratory

Shortness of breath
 Wheezing
 Persistent cough
 Bloody sputum

1	2	3	4

GI

Change in appetite
 Difficulty swallowing
 Heartburn
 Abdominal pain
 Swelling of / in abdomen
 Belching or excessive gas
 Nausea or vomiting
 Rectal bleeding or dark stools

1	2	3	4

GI cont.

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Skin

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 Dry skin
 Itching
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Neuro

Headaches
 Dizziness or loss of balance
 Fainting
 Memory loss, poor concentration
 Change in sensation
 Weakness or numbness
 Poor coordination

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Psychiatric

Mood swings
 Sleeplessness
 Nervousness, anxiety, fear
 Depression, grief or sadness
 Hard to find pleasure
 Family problems
 Occupational concerns

1	2	3	4

Hematologic / Infectious

Lymph node swelling or pain
 Engaged in risky sex or drugs

1	2	3	4

Allergy

Allergy symptoms

Any other concerns: _____