REVIEW OF SYMPTOMS

Name: Date:

	(symptoms within the past 12 months; "in past' = > 12 months ago)	Never	In past	Mild/ Occ	Moderate /Regular	Severe/ Frequent	Please describe	**PLEASE LEAVE BLANK**
Const	Not feeling well							
	Weight loss							
	Weight gain							
	Low body temperature							
	Fevers							
	Fatigue							
	Night sweats							
Psych	Anxiety							
	Irritability							
	Panic							
	Depression							
Musc-Skel	Joint pain							
	Joint heat or swelling							
	Weakness							
	Muscle pains/spasms							
Neuro	Numbness							
	Tingling							
	Poor Memory/Concentration							
	Falls							
	Fainting							
	Headache							
ADL's	Difficulty with Buttons/Laces							
	Difficulty Climbing Stairs							
	Difficulty Walking							
	Difficulty Lifting							
	Difficulty Changing Position							
	Difficulty Driving							
Heme	Bruising							
	Bleeding							
	Calf Tenderness							
Eyes	Blurred vision							
	Double vision							
	"Floaters"							
	Dry Eyes							
ENT	Sore throat							
	Difficulty Swallowing							
	Dizzyness							
	TMJ							
	Dental Work							
	Silver (Amalgum) Fillings Removed							
Cardiac	Chest Pain							
	Palpitations							
	Shortness of Breath with Exertion							
	Shortness of Breath at rest							
Vasc	Swelling in Extremities							
	Calf Tenderness							
	Swollen veins							
	Cold/Hot/Red/Blue Extremities							
Resp	Cough							
	Chest Tight/ Difficult Catching Breath							
	Wheezes							
GU	Urgency to void urine							
	Difficulty voiding							
	Losing urine (cough, sneeze, etc.)							
Immun	Enlarged lymph nodes							
	Yeast/Fungal infection(s)							
	Cold sores/Herpes mouth / genitals							
	Easily get colds or sinus infection							
	Other infections (please list)							

REVIEW OF SYMPTOMS

Name: Date:

(symptoms within the past 12 months)		Never	In past	Mild/ Occ	Moderate /Regular	Severe/ Frequent	Please describe	**PLEASE LEAVE BLANK**
Sleep	Problems falling asleep							
	Problems staying asleep							
	Early awakening							
	Snoring							
	Restlessness							
	Not refreshed in am							
	Daytime sleepyness							
	Need/takes naps							
	Average # hours/night							
GI	Pain							
	Bad Breath							
	Burping							
	Heartburn							
	Problems Swallowing							
	Reflux/repeating (list foods)							
	Nausea/Vomiting							
	Bloating after meals							
	Gas/Flatulence							
	Constipation							
	Diarrhea							
	Hemorrhoids							
	Itchy Anus							
	Stools float/Yellow stools							
	Blood in Stools/Stools Black							
Endo	Heat/Cold Intolerance							
	Frequent thirst							
	Frequent hunger							
	Irritable/shaky when hungry							
	Frequent urination							
	Loss of height							
	Grey Hair (age first noticed)							
	Decreased libido							
Skin	Rashes							
	Dry							
	Itchy							
	Hair Loss							
	Fragile Nails							
	Yellow/thick nails							
	Other lesions							
Women	Fibrocystic breasts							
	Periods irregular/stopped							
	PMS							
	Increased hair							
	Acne							
	Hot flashes							
	Age periods started/ended							
	Days of cycle/period (i.e. 28/4)							
	# of pregnancies/miscarriages							
	Pill/Hormones (list ages)							
Men	Frequent Urination							
	Waking to Urinate							
	Erectile Dysfunction							
	Other (Pain):							

Other Strange or Recurrent Symptoms, even if dismissed by other doctors: Please describe on back of page: symptom, location in body, how often, how severe, what makes it better or worse. ☐ see back

PLEASE LEAVE BLANK (Complete >= 10, Extended 2-9, Brief 1)

☐ Without interval change from ROS obtained (give date):	☐ All other systems negative
☐ Unable to obtain from patient due to	Signature