



## Review Of Symptoms

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name of Primary Care Provider (PCP):** \_\_\_\_\_ **Send letter to PCP?** No Yes

**PLEASE INDICATE BELOW. ARE YOU CURRENTLY EXPERIENCING ANY OF THESE SYMPTOMS:**

**General, constitutional**

None:

Poor health lately ..... no yes  
Recent weight change ..... no yes  
Fever ..... no yes  
Fatigue ..... no yes

**Eyes and vision**

None:

Eye disease or injury ..... no yes  
Wear glasses or contact lenses ..... no yes  
Blurred or double vision ..... no yes  
Glaucoma ..... no yes

**Ears, nose, throat**

None:

Hearing loss ..... no yes  
Ringing in the ears ..... no yes  
Earaches or drainage ..... no yes  
Sinus problems ..... no yes  
Nose bleeds ..... no yes  
Mouth sores ..... no yes  
Bleeding gums ..... no yes  
Bad breath or bad taste ..... no yes  
Sore throat or voice change ..... no yes  
Swollen glands in neck ..... no yes

**Heart and Cardiovascular**

None:

Heart trouble or murmur ..... no yes  
Chest pains ..... no yes  
Sudden heartbeat changes ..... no yes  
Swelling of feet, ankles, hands ..... no yes

**Respiratory**

None:

Frequent coughing ..... no yes  
Spitting up blood ..... no yes  
Shortness of breath ..... no yes  
Asthma or wheezing ..... no yes

**Gastrointestinal**

None:

Loss of appetite ..... no yes  
Change in bowel movements ..... no yes  
Nausea or vomiting ..... no yes  
Frequent diarrhea ..... no yes  
Painful bowel movements or constipation ..... no yes  
Blood in stool ..... no yes  
Stomach pain ..... no yes

**Genitourinary**

None:

Frequent urination ..... no yes  
Burning or painful urination ..... no yes  
Blood in urine ..... no yes  
Change in force or strain with urination ..... no yes  
Incontinence or dribbling ..... no yes  
Kidney stones ..... no yes  
Sexual difficulty ..... no yes  
Painful periods ..... no yes  
Irregular periods ..... no yes  
Vaginal discharge ..... no yes

**Musculoskeletal**

None:

Joint pain ..... no yes  
Joint stiffness or swelling ..... no yes  
Weakness of muscles/joints ..... no yes  
Muscle pain or cramps ..... no yes  
Back pain ..... no yes  
Cold extremities ..... no yes  
Difficulty in walking ..... no yes

**Skin and breasts**

None:

Rash or itching ..... no yes  
Change in moles ..... no yes  
Change in hair or nails ..... no yes  
Change in skin color ..... no yes  
Breast pain ..... no yes  
Breast lump ..... no yes  
Breast discharge ..... no yes

**Neurologic**

None:

Frequent or recurrent headaches ..... no yes  
Light headed or dizzy ..... no yes  
Convulsions or seizures ..... no yes  
Numbness or tingling sensations ..... no yes  
Tremors ..... no yes  
Paralysis ..... no yes  
Stroke ..... no yes  
Head injury ..... no yes

**Psychiatric**

None:

Memory loss or confusion ..... no yes  
Nervousness ..... no yes  
Depression ..... no yes  
Sleep problems ..... no yes

**Endocrine**

Glandular or hormone problem ..... no yes  
Thyroid disease ..... no yes  
Diabetes ..... no yes  
Excessive thirst or urination ..... no yes  
Heat or cold intolerance ..... no yes  
Dry skin ..... no yes  
Change in hat or glove size ..... no yes

**Hematologic/Lymphatic**

None:

Slow to heal after cuts ..... no yes  
Easily bruise or bleed ..... no yes  
Anemia ..... no yes  
Phlebitis ..... no yes  
Transfusion ..... no yes  
Swollen glands ..... no yes

**Patient sign here:** \_\_\_\_\_

**Date:** \_\_\_\_\_