

Review of Symptoms

Are you currently, or have you had, problems with:

<i>Constitutional</i>	Circle One		<i>Respiratory</i>	Circle One	
Weight Gain	Yes	No	Asthma	Yes	No
Weight Loss	Yes	No	Cough up Blood	Yes	No
Night Sweats	Yes	No	TB	Yes	No
Insomnia	Yes	No	Pneumonia	Yes	No
<i>EYES</i>			Trouble Breathing at night	Yes	No
Double Vision	Yes	No	Snoring	Yes	No
Visual Loss	Yes	No	<i>Gastrointestinal</i>		
Hearing Loss	Yes	No	Indigestion or Heartburn	Yes	No
Noise/ringing in ears	Yes	No	Hepatitis	Yes	No
Nasal congestion	Yes	No	Jaundice	Yes	No
Nasal Drainage	Yes	No	Blood in Stool	Yes	No
Sore Throat	Yes	No	Black, Tarry Stool	Yes	No
Trouble Swallowing	Yes	No	<i>Genitourinary</i>	Yes	No
Hoarseness	Yes	No	Bladder trouble	Yes	No
<i>Cardiovascular</i>			Prostate Disease	Yes	No
Chest Pain or Angina	Yes	No	Kidney Disease	Yes	No
Heart Trouble	Yes	No	<i>Musculoskeletal</i>		
Rheumatic Fever	Yes	No	Arthritis	Yes	No
Heart murmur	Yes	No	<i>Endocrine</i>	Yes	No
High Blood Pressure	Yes	No	Diabetes	Yes	No
<i>Neurological</i>			Thyroid Disease	Yes	No
Numbness	Yes	No	<i>Hematologic</i>		
Weakness	Yes	No	Bleeding Disorder	Yes	No
Stroke	Yes	No	Easy Bleeding	Yes	No
Headache	Yes	No			
<i>Psychiatric</i>					
Depression	Yes	No			
Other	Yes	No			
<i>Allergic/Immunologic</i>					
Sneezing	Yes	No			
Itchy Eyes/ Nose	Yes	No			
Itchy Throat	Yes	No			
Skin rash	Yes	No			
HIV	Yes	No			

The above information is accurate to the best of my knowledge.

Patient Signature *Date*

I have reviewed the above information with the patient. _____