



Check the appropriate boxes for symptoms you are *currently* experiencing.

Eyes

- Pain Dry Watery / Itchy Vision loss Blurring / Double vision Discharge

Ear, Nose, Throat

- Ear Pain Hearing loss Ringing Dizzy Stuffy Nose Runny Nose
 Hoarseness Sore throat Trouble swallowing

Cardiovascular

- Chest Pain Palpitations Fainting Shortness of breath with activity
 Shortness of breath while resting Swelling in legs

Respiratory

- Cough Shortness of breath Excessive sputum Coughing up blood Wheezing

Gastrointestinal

- Nausea Vomiting Diarrhea Constipation

Genitourinary

- Pain urinating Waking up to urinate Blood in urinate Discharge
 Trouble starting Trouble stopping Genital sores

Musculoskeletal

- Back pain Joint pain Joint swelling Muscle cramps Muscle weakness Stiffness

Skin

- Scarring Eczema Rashes Skin cancer Suspicious lesions

Neurologic

- Paralysis Focal loss of sensation Blackouts Seizures
 Restless legs Insomnia Sleep Apnea Snoring

Psychiatric

- Depression Anxiety Memory loss Mental disturbance Suicidal
 Hallucinations Paranoia

Endocrine

- Cold intolerance Heat intolerance Always thirsty Always hungry

HemeLymphatic

- Abnormal bruising Abnormal bleeding Enlarged lymph nodes
 Tender lymph nodes Frequent illnesses

Allergic / Immune

- Ocular allergies Nasal allergies Allergic dermatitis Recurring infections
 HIV exposure Immuno-compromised

Signature: _____ **Date:** _____

Patient or Legal Guardian