

REVIEW OF SYMPTOMS *(in the past month)*



Name: _____ DOB: _____ Date: _____

N=Never, M=Moderate, S=Severe

Please note whether you have had any of the following symptoms *in the past month*:

<u>CONSTITUTIONAL:</u>	N	M	S	<u>NEUROLOGIC:</u>	N	M	S	<u>MUSCULOSKELETAL:</u>	N	M	S	<u>PSYCHIATRIC:</u>	N	M	S
Fever				Dizziness				Joint Pain				Anxiety			
Chills				Memory problems				Joint buckling				Sense of doom			
Excessive sweating				Fainting				Joint locking				Unstable mood			
Weight change				Confusion				Joint swelling				Hallucinations			
Poor sleep				Headaches				Joint immobility				Depressed mood			
Can't fall asleep				Loss of coordination				Muscle pain				Lost Motivation			
Waking up often				Loss of balance				Muscle stiffness				Change in appetite			
Waking up early				Falling				Muscle twitching				Loss of energy			
Daytime sleepiness				Numbness/tingling				Muscle spasms				Poor concentration			
Excessive snoring				Muscle weakness				Cardiovascular:				Guilty feelings			
Eyes				Fatigue				Palpitations				Thoughts of suicide			
Blurred vision				Tremor (shaking)				Chest discomfort				Desire to hurt self			
Pain				Intolerance to heat				Shortness of breath				Desire to hurt others			
Double vision				Intolerance to cold				Swelling in ankles				Genitourinary:			
Floaters				Skin:				Respiratory:				Difficulty urinating			
Ears, Nose, Throat				Rash				Cough				Frequent urination			
Hearing loss				Dryness				Difficulty breathing				Painful urination			
Sore throat/voice change				Gastrointestinal:				<i>Inhalation</i> wheezing/asthma				Incontinence			
Vertigo (spinning room)				Difficulty chewing				<i>Exhalation</i> wheezing/asthma				Night-time urination			
High-pitched tinnitus				Difficulty swallowing				Allergy/Immune:				Oral/Dental:			
Low-pitched tinnitus				Abdominal pain				Burning				Tooth Pain			
Sinus congestion				Nausea				Itching				Painful Gums			
Endocrine:				Heartburn				Hives				Bleeding Gums			
Blurred vision				Vomiting				HIV exposure				Broken tooth			
Heat or cold intolerance				Diarrhea				Frequent infections				Mouth Sores			
Hair loss				Constipation				Heme/Lymph:				Herpes Simplex			
Excessive thirst				Alternating diarrhea/constip.				Bruising				Date of last dental visit?			
Diabetes				Bloody stool				Lumps in armpits, groin, neck, etc.				What services were performed?			
Thyroid problems				Hemorrhoids				Bleeding problems							
Cold hands & feet				Black Stool				Swelling							