

### Review of Symptoms

Patient Instructions: Check if you are currently experiencing any of the following conditions.

Patient Name	
Date	

Body Systems	Check all that apply:	Provider Comments
General / Constitutional	<input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Normal Energy level <input type="checkbox"/> Fatigue <input type="checkbox"/> Pain <input type="checkbox"/> Change in level of activities	
Skin	<input type="checkbox"/> Rash <input type="checkbox"/> Nodules <input type="checkbox"/> Itchy skin <input type="checkbox"/> Wound or injury <input type="checkbox"/> Lump	
HEENT:	<input type="checkbox"/> Double vision <input type="checkbox"/> Loss of vision <input type="checkbox"/> Blind spot in vision <input type="checkbox"/> Pink or red eye <input type="checkbox"/> Impaired vision <input type="checkbox"/> Visual changes <input type="checkbox"/> Nosebleed <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Oral ulcers <input type="checkbox"/> Gum bleeding <input type="checkbox"/> Dry mouth <input type="checkbox"/> Sore throat <input type="checkbox"/> Runny nose <input type="checkbox"/> Mouth pain <input type="checkbox"/> Sinus pain <input type="checkbox"/> Ringing in the ear <input type="checkbox"/> Dizziness <input type="checkbox"/> Hearing changes	
Chest/Lungs:	<input type="checkbox"/> Cough <input type="checkbox"/> Coughing up bloody sputum/mucus <input type="checkbox"/> Chest pain when you take deep breaths <input type="checkbox"/> Wheezing <input type="checkbox"/> Difficulty breathing	

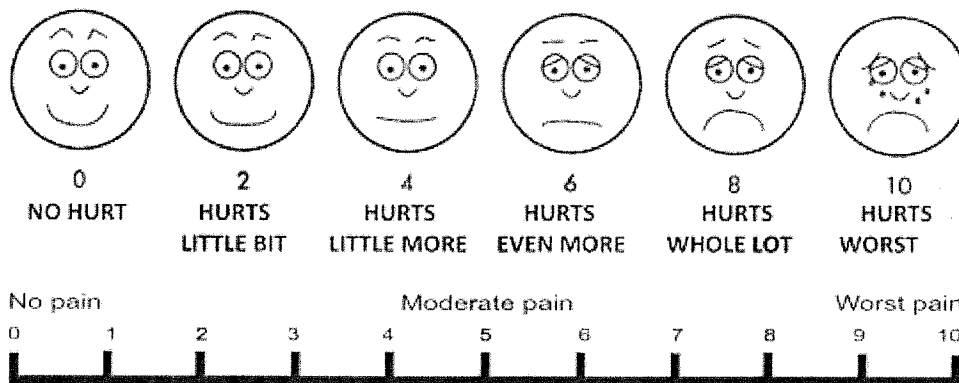
Body Systems	Check all that apply:	Provider Comments
Cardiovascular	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Swelling in the arm(s) <input type="checkbox"/> Swelling in the leg(s)	
Gastrointestinal	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Abdominal cramping <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool <input type="checkbox"/> Tarry stools <input type="checkbox"/> Yellow skin/eyes <input type="checkbox"/> Heartburn <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Excessive thirst.	
Genitourinary	<input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Need to urinate at night <input type="checkbox"/> Inability to control urination <input type="checkbox"/> Frequent urination	
Neurologic	<input type="checkbox"/> Confusion <input type="checkbox"/> Seizures <input type="checkbox"/> Fainting <input type="checkbox"/> Tremor <input type="checkbox"/> Speech change <input type="checkbox"/> Headache <input type="checkbox"/> Hiccups <input type="checkbox"/> Dizziness <input type="checkbox"/> Migraines <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Weakness <input type="checkbox"/> Changes in coordination or balance <input type="checkbox"/> Experience instability leading to falls	
Musculoskeletal	<input type="checkbox"/> Muscle pain <input type="checkbox"/> Swollen joints <input type="checkbox"/> Joint redness <input type="checkbox"/> Back pain	

Body Systems	Check all that apply:	Provider Comments
Lymph Nodes	<input type="checkbox"/> Enlargement of lymph nodes	
Endocrine	<input type="checkbox"/> Hot flashes <input type="checkbox"/> Feeling cold	
Allergic/Immunologic	<input type="checkbox"/> Eczema – red and/or itchy skin <input type="checkbox"/> Frequent respiratory infections <input type="checkbox"/> Hives <input type="checkbox"/> Frequent skin infections	
Psychiatric	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Changes in concentration <input type="checkbox"/> Change in sleep	

Other Notes:	
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How would you rate your pain on a scale of 0 to 10?

Pain Assessment



Location of Pain		Provider Comments
What makes it better?		
What makes it worse?		