

Patient's Name _____ **Date of Birth:** _____

*Please check **only persistent/on-going symptoms** and explain how long you have had symptoms.*

Constitutional

- Fatigue _____
- Fever _____
- Victim/domestic violence _____
- Weight gain (unintentional) _____
- Weight loss (unintentional) _____

Ears/Nose/Throat

- Sore throat _____

Cardiovascular

- Varicose veins _____

Respiratory

- Wheezing _____

Gastrointestinal

- Abdominal pain _____
- New lack of appetite _____
- Bloating _____
- Bloody/bright red bleeding in stools _____
- Constipation _____
- Diarrhea _____
- Heartburn _____
- Acid reflux _____
- Hemorrhoids _____
- Uncontrollable loss of stool _____
- Nausea _____
- Vomiting _____
- Change in stool size _____

Neurological

- Headaches _____
- Seizures _____

Hematologic/lymphatic

- History of blood transfusion _____
- Leg/lung blood clots in veins (history of) _____
- Leg/lung blood clots in veins (current) _____

Psychiatric

- Crying spells _____
- Depression _____
- Sadness _____
- Recreational drug use _____
- Sleep disturbance _____
- Suicidal thoughts _____

Genitourinary

- Painful periods _____
- Pain with sex _____
- Pain with urination _____
- Sores on vulvar/bottom area _____
- Bloody urine _____
- Multiple partners in lifetime _____
- Frequent bladder infections _____
- Recurrent vaginal infections _____
- Incomplete bladder emptying _____
- Irregular menstrual cycle _____
- Heavy periods _____
- Lack of periods _____
- Bleeding after or with sex _____
- Post-menopausal bleeding _____
- Frequent nighttime urination _____
- Uncontrollable loss of urine _____
- vaginal discharge _____
- vaginal itching _____
- sexual abuse/rape (history of) _____
- sexual abuse/rape (current) _____

Integumentary/Breast

- unusual, irritated, or changing mole(s) _____
- breast mass _____
- breast skin changes _____
- breast tenderness _____
- nipple discharge _____
- Self-breast exams? Yes _____ No _____

Endocrine

- hair loss _____
- heat/cold intolerance _____
- new excessive hair growth _____
- hot flashes _____
- mood swings _____
- night sweats _____
- PMS _____