Patient Name: _____ **DOB:** _____ **Date:**_____

Chief Complaint:

***Check* only symptoms that apply to your concern for today's visit.**

Constitutional
- ☐ Temperature
- ☐ Chills
- ☐ Muscle Aches
- ☐ Poor Appetite
- ☐ Poor Sleep
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss

Eyes
- ☐ Discharge
- ☐ Redness
- ☐ Itchiness
- ☐ Vision Changes

Ears
- ☐ Pain
- ☐ Discharge
- ☐ Pressure
- ☐ Difficulty Hearing

Nose
- ☐ Bleeds
- ☐ Discharge
- ☐ Post Nasal Drip
- ☐ Congestion
- ☐ Sinus Pressure

Throat
- ☐ Soreness
- ☐ Redness
- ☐ Difficulty Speaking/Swallowing
- ☐ Exudate/Pus

Cardiovascular/Respiratory
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Lower Extremity Swelling
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Cough
- ☐ Phlegm

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in Bowel Habits
- ☐ Bloody Stool
- ☐ Black Stool
- ☐ Hemorrhoids

Urinary
- ☐ Frequency
- ☐ Urgency
- ☐ Hesitancy
- ☐ Night Time Frequency
- ☐ Urinary Incontinence
- ☐ Blood in Urine

Female
- ☐ Pregnant
- ☐ Irregular Menses
- ☐ Missed Menses
- ☐ Abnormal Bleeding
- ☐ Painful Sex
- ☐ Vaginal Discharge
- ☐ Burning w/ Urination

Male
- ☐ Penile Discharge
- ☐ Erectile Dysfunction

Musculoskeletal
- ☐ Joint Pain
- ☐ Swelling
- ☐ Stiffness
- ☐ Muscle Pain

Neurological
- ☐ Headache
- ☐ Dizziness
- ☐ Weakness
- ☐ Difficulty Walking
- ☐ Numbness
- ☐ Tingling

Psychiatric
- ☐ Depressed
- ☐ Anxiety
- ☐ Suicidal Ideation

Hematological/Lymph
- ☐ Bruising
- ☐ Fatigue
- ☐ Anemia
- ☐ Recent Corticosteroid Treatment
- ☐ Heat Intolerance
- ☐ Cold Intolerance

Skin
- ☐ Rash
- ☐ Lesions
- ☐ Hair Loss

FOR CLINIC USE ONLY:

 **Weight**:_____lbs  **Pulse**:_____bpm  **Oxygen Saturation**:_____%

 **Height**:____in  **Temperature**:_____°F  **Blood Pressure**:_____/____  _____**/10**