Patient Name: _____ DOB: _____ Date: _____

Chief Complaint:

Review of Symptoms: Please circle Y or N if you are experiencing any of these symptoms TODAY.

Constitutional	**Constitutional**	**Genitourinary**	**Genitourinary**
Temperature	Y or N	Frequency	Y or N
Chills	Y or N	Urgency	Y or N
Muscle Aches	Y or N	Hesitancy	Y or N
Poor Appetite	Y or N	Night Time Frequency	Y or N
Poor Sleep	Y or N	Urinary Incontinence	Y or N
Night Sweats	Y or N	Blood In Urine	Y or N
Weight Gain	Y or N	**Female**	**Female**
Weight Loss	Y or N	Pregnant	Y or N
Eyes	**Eyes**	Irregular Menses	Y or N
Discharge	Y or N	Missed Menses	Y or N
Redness	Y or N	Abnormal Bleeding	Y or N
Itchiness	Y or N	Painful Sex	Y or N
Vision Changes	Y or N	Vaginal Discharge	Y or N
Ears	**Ears**	Burning w/ Urination	Y or N
Pain	Y or N	**Male**	**Male**
Discharge	Y or N	Penile Discharge	Y or N
Pressure	Y or N	Erectile Dysfunction	Y or N
Difficulty Hearing	Y or N	**Musculoskeletal**	**Musculoskeletal**
Nose	**Nose**	Joint Pain	Y or N
Nose Bleeds	Y or N	Swelling	Y or N
Discharge	Y or N	Stiffness	Y or N
Post Nasal Drip	Y or N	Muscle Pain	Y or N
Congestion	Y or N	**Neurological**	**Neurological**
Sinus Pressure	Y or N	Headache	Y or N
Throat	**Throat**	Dizziness	Y or N
Soreness	Y or N	Weakness	Y or N
Redness	Y or N	Difficulty Walking	Y or N
Difficulty Speaking/Swallowing	Y or N	Numbness	Y or N
Exudate/Pus	Y or N	Tingling	Y or N
Gastrointestinal	**Gastrointestinal**	**Psychiatric**	**Psychiatric**
Abdominal Pain	Y or N	Depressed	Y or N
Heartburn	Y or N	Anxiety	Y or N
Nausea	Y or N	Suicidal Ideation	Y or N
Vomiting	Y or N	**Hematological/Lymph**	**Hematological/Lymph**
Diarrhea	Y or N	Bruising	Y or N
Constipation	Y or N	Fatigue	Y or N
Change in Bowel Habits	Y or N	Anemia	Y or N
Bloody Stool	Y or N	Recent Corticosteroid Treatment	Y or N
Black Stool	Y or N	Heat Intolerance	Y or N
Hemorrhoids	Y or N	Cold Intolerance	Y or N
Cardiovascular/Respiratory	**Cardiovascular/Respiratory**	**Skin**	**Skin**
Shortness of Breath	Y or N	Rash	Y or N
Wheezing	Y or N	Lesions	Y or N
Lower Extremity Swelling	Y or N	Hair Loss	Y or N
Chest Pain	Y or N		
Palpitations	Y or N		
Cough	Y or N		
Phlegm	Y or N		