Symptoms Check List

Patient's Name:	Date:

Please mark only those symptoms you are currently experiencing.

1.	**General**
	Fatigue
	Night Sweats
	Fever
	Unexplained weight gain
	Unexplained weight loss
	Swollen feet or ankles
	Trouble getting to sleep
	Trouble staying asleep
	Waking up too early and can't get back to sleep
2.	**Nervous System**
	Seizures Frequency:
	Headaches Frequency:
	Memory Loss
	Balance problems
	Light headedness
	Sense of spinning
	Weakness
Areas:	
	Numbness
Areas:	
3.	**Vision**
	Blurred vision at near objects
	Blurred vision at far objects
	Double vision
	Spots in front of eyes
	Caracts
4.	**Hearing**
	Hard of hearing
	Ringing in the ears
5.	**Musculoskeletal**
	Pain in joints
Areas:	
	Pain in muscles
Areas:	
	Pain in jaw
6.	**Cardiovascular**
	Chest pain
	Pressure in chest
	High blood pressure
	Low blood pressure
7.	**Respiratory**
	Shortness of breath
	☐ on exertion ☐ at rest ☐ night
	Cough
	Sputum production
	Dry mouth
8.	**Gastrointestinal**
	Trouble chewing
	Trouble swallowing
	Stomach pain
	Nausea
	Vomiting
	Diarrhea
	Constipation
	Trouble controlling bowel movements
9.	**** Females Only ****
	Change in menstrual cycle
When/How long?	

Explain:	
10.	**Genitourinary**
	Pelvic pain
	Loss of sexual interest
	Problems in sexual function
	Urinating too frequently
	Pain or burning when urinating
	Losing urine involuntarily
Birth Control Method:	
11.	**Endocrine**
	Diabetes
	Thyroid ◻ hyperglycemic ◻ hypoglycemic ◻ emotional
12.	**Emotional**
	Nervousness
	Anxiety
	Depression
	Irritable
	Panic Spells
	Moodiness
13.	**Alcohol**
	Does NOT drink alcohol
	Year quit:
	Does drink alcohol
Specify type:	
Frequency:	# of years:
14.	**Caffeine**
Amount per day or week:	
	Caffeinated Coffee / Total servings per day:
	Caffeinated Tea / Total servings per day:
	Caffeinated Soft drinks / Total servings per day:
Other/Name:	
15.	**Tobacco**
	Chewing Tobacco
Frequency:	# of years:
	Smoker ◻ Cigarette ◻ Cigars
Frequency:	# of years:
16.	**Other Personal Habits**
	Marijuana
Frequency:	# of years:
	Other Street Drug:
Frequency:	# of years:
	Other Street Drug:
Frequency:	# of years:
16.	**Travel**
Have you traveled outside of the State of Colorado in the last 3 months? ◻ Yes ◻ No	
Where?	
Have you traveled outside of the United States in the last 6 months? ◻ Yes ◻ No	
Where?	

Who is filling out this form?

◻ Patient
◻ Interpreter
◻ Office Staff
◻ Family Member

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◻ Friend/Other:

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