Marking Instructions
Please use a #2 pencil.
Fill in the complete oval as shown...

Please mark all symptoms you are **CURRENTLY** experiencing.
Mark all that apply. If no symptoms, please mark “NONE.”

### Constitutional Symptoms
- fatigue
- fever
- night sweats
- weight loss (unintentional)

### Eyes
- blurred or double vision
- eye pain or soreness

### Ear / Nose / Mouth / Throat
- earache
- mouth sores
- nosebleeds
- sore throat
- voice change

### Cardiovascular
- arrhythmia
- chest pain or angina
- edema / leg swelling
- palpitations

### Respiratory
- asthma or wheezing
- chronic cough
- coughing blood
- shortness of breath

### Gastrointestinal
- abdominal pain
- change in bowel habits
- constipation
- difficulty swallowing
- frequent diarrhea
- heartburn
- loss of appetite
- nausea
- painful swallowing
- rectal bleeding
- rectal pain
- vomiting
- vomiting blood

### Female Genitourinary
- blood in urine
- kidney stones
- painful urination
- pelvic pain
- urine leakage
- vaginal bleeding
- vaginal discharge
- last menstrual period: ________________________

### Male Genitourinary
- blood in urine
- change in urinary stream
- excessive urination at night
- frequent urination
- impotence
- kidney stones
- penile discharge
- penile lesions
- testicular mass
- testicular pain
- urine leakage
- urinary urgency

### Musculoskeletal
- back pain
- joint pain
- muscle pain
- muscle weakness

### Neurological
- convulsions or seizures
- fainting
- frequent or recurring headaches
- loss of strength (paralysis)
- memory loss
- numbness or tingling sensation
- trouble walking

### Endocrine
- cold intolerance
- excessive thirst
- heat intolerance
- hypoglycemia

### Hematologic / Lymphatic
- easy bruising
- excessive bleeding
- swollen glands

### Integumentary (Skin)
- change in skin color
- hair loss
- jaundice
- new skin lesion
- skin rashes

### Psychiatric
- depression
- insomnia
- nervousness or anxiety
- psychiatric disorder

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Please answer every question.

**PLEASE PRINT PATIENT’S LAST NAME**

**PLEASE PRINT PATIENT’S FIRST NAME**

**PATIENT’S DATE OF BIRTH**

- Month
- Day
- Year

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STAFF: Handwritten responses must be entered **MANUALLY**

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