



# Patient Symptoms

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Do you currently have any of the following symptoms? Please check Yes or No.**

### General:

- |                  | Yes                      | No                       |
|------------------|--------------------------|--------------------------|
| Fevers           | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of appetite | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue          | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight loss      | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight gain      | <input type="checkbox"/> | <input type="checkbox"/> |

### Respiratory:

- |                             |                          |                          |
|-----------------------------|--------------------------|--------------------------|
| Cough                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath at rest | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive sputum            | <input type="checkbox"/> | <input type="checkbox"/> |
| Coughing blood              | <input type="checkbox"/> | <input type="checkbox"/> |
| Wheezing                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Snoring                     | <input type="checkbox"/> | <input type="checkbox"/> |

### Genitourinary:

- |                      |                          |                          |
|----------------------|--------------------------|--------------------------|
| Painful urination    | <input type="checkbox"/> | <input type="checkbox"/> |
| Urinary frequency    | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody urine         | <input type="checkbox"/> | <input type="checkbox"/> |
| Night time urination | <input type="checkbox"/> | <input type="checkbox"/> |

### Musculoskeletal:

- |                |                          |                          |
|----------------|--------------------------|--------------------------|
| Back pain      | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint pain     | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint swelling | <input type="checkbox"/> | <input type="checkbox"/> |
| Muscle cramps  | <input type="checkbox"/> | <input type="checkbox"/> |
| Hoarseness     | <input type="checkbox"/> | <input type="checkbox"/> |

### Cardiovascular:

- |                                     | Yes                      | No                       |
|-------------------------------------|--------------------------|--------------------------|
| Chest pain or discomfort            | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain with activity            | <input type="checkbox"/> | <input type="checkbox"/> |
| Palpitations or fluttering          | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of consciousness               | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath with activity   | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath when lying flat | <input type="checkbox"/> | <input type="checkbox"/> |
| Awakening short of breath           | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg swelling                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Leg cramps when walking             | <input type="checkbox"/> | <input type="checkbox"/> |

### Gastrointestinal:

- |                |                          |                          |
|----------------|--------------------------|--------------------------|
| Nausea         | <input type="checkbox"/> | <input type="checkbox"/> |
| Vomiting       | <input type="checkbox"/> | <input type="checkbox"/> |
| Diarrhea       | <input type="checkbox"/> | <input type="checkbox"/> |
| Constipation   | <input type="checkbox"/> | <input type="checkbox"/> |
| Abdominal pain | <input type="checkbox"/> | <input type="checkbox"/> |
| Black stool    | <input type="checkbox"/> | <input type="checkbox"/> |
| Bloody stool   | <input type="checkbox"/> | <input type="checkbox"/> |

### Endocrine:

- |                         |                          |                          |
|-------------------------|--------------------------|--------------------------|
| Cold intolerance        | <input type="checkbox"/> | <input type="checkbox"/> |
| Heat intolerance        | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive thirst        | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive urination     | <input type="checkbox"/> | <input type="checkbox"/> |
| Excessive desire to eat | <input type="checkbox"/> | <input type="checkbox"/> |

### Heme/Lymphatic:

- |                   | Yes                      | No                       |
|-------------------|--------------------------|--------------------------|
| Abnormal bruising | <input type="checkbox"/> | <input type="checkbox"/> |
| Abnormal bleeding | <input type="checkbox"/> | <input type="checkbox"/> |
| Nose Bleeds       | <input type="checkbox"/> | <input type="checkbox"/> |

### Neurological:

- |                    |                          |                          |
|--------------------|--------------------------|--------------------------|
| Weakness           | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches          | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness           | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures           | <input type="checkbox"/> | <input type="checkbox"/> |
| Tremors            | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinning sensation | <input type="checkbox"/> | <input type="checkbox"/> |

### Skin:

- |         |                          |                          |
|---------|--------------------------|--------------------------|
| Rash    | <input type="checkbox"/> | <input type="checkbox"/> |
| Itching | <input type="checkbox"/> | <input type="checkbox"/> |
| Dryness | <input type="checkbox"/> | <input type="checkbox"/> |

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_