Name_____ Date_____

Symptom Review

Circle the symptoms or circumstances that apply to you **now.**
UNDERLINE the ones which you have experienced in the past

GENERAL

Poor Appetite	Cold hands or feet	Numb or tingling limbs
Excessive Appetite	Cold Abdomen	Poor coordination
Food Cravings	Fevers	Tremors
Insomnia	Chills	Vertigo
Poor or Heavy Sleep	Nights Sweats	Nerve Pain or Neuralgia
Fatigue	Hot Sensations	Swelling in hands or feet
Change in Appetite	Strong Thirst (hot/cold drinks)	Bleed or bruise easily
Weight loss:_____pounds	Peculiar tastes/smells_____	

Sudden energy drop at_____time

_____

_____

SKIN AND HAIR

Rashes	Ulcerations	Itching
Eczema	Pimples	Loss of Hair
Dryness	Hives	Moles or lumps that change

Other hair or skin problems_____

HEAD AND FACE

Headache	Dizziness	Memory Loss
Migraines	Fainting	Seizures

_____

EYES/ EARS/ NOSE

Blurred Vision/Floaters	Eyelid Problems	Night Blindness
Poor Hearing	Earaches	Discharge from ear
Ringing in Ear		
Frequent Colds	Sinus Problems	Nosebleeds
Mucous: Color_____		

_____

MOUTH/ THROAT

Gum/Teeth Problems	Tongue Problems	Jaw Problems
Unusual tastes	Sores	Grinding Teeth
Dry Mouth	Missing teeth	
Recurrent Sore Throat	Hoarseness	Difficulty Swallowing
Sensation of something stuck in throat		

_____

CHEST AND THORAX

Chest Pain	Palpitations	Bronchitis
Chest Tightness	Irregular Heartbeat	Pneumonia
Difficulty Inhaling	Heart Murmurs	Emphysema
Difficulty Exhaling	Pacemaker	Phlebitis

Production of Phlegm: what color_____

_____

GASTROINTESTINAL

Nassau/Vomiting	Diarrhea	Bowel Movement:
Gas	Constipation	_____Frequency
Belching	Rectal Pain	_____Color
Pain or Cramps	Bloody Stool	_____Odor
Bad Breath	Hemorrhoids	_____Texture

Laxative use:_____/week ; type_____

_____

GENITO-URINARY

Pain on Urination	Frequent Urination	Blood in Urine
Unable to Hold Urine	Kidney Stones	Difficulty starting or stopping urine

Wake up to urinate: Number of times per night_____at TIme_____

_____

MUSCULOSKETAL

Neck Pain	Muscle Pain	Back Pain
Joint Pain	Other Joint or Bone Problem	

_____

_____

MALES

Reduced sexual energy	Discharges	Pain in genitals
Premature ejaculation	Impotence	Prostate Problems

_____

FEMALES

Date of last menstration _____ Are you pregnant _____

Are you using birth control? _____

Date of last PAP _____

Do you have breast tenderness _____, or lumps?_____

Age at first menstration_____

Number of pregnancies _____

Dates of births_____ _____ _____ Miscarrages_____ Abortions_____

Current menstral history

Legnth of cycle from first day of bleeding to first day of bleeding _____

Number of days of bleeding _____ Color of blood _____ Clots?_____

Any symptoms associated with menstruation?

Have you had any gynecological surgeries?

DO YOU HAVE ANY OTHER CONCERNS?