Name_____ DOB_____

Please check any symptoms you have had in the past 3 months. **☐ I have had none of these symptoms**

General	☐ Poor appetite ☐ Fever/chills ☐ Weight loss ☐ Weight gain ☐ Faintness ☐ Fatigue ☐ Headaches ☐ Decreased Hearing ☐ Nosebleeds ☐ Weakness ☐ Hoarseness ☐ Painful Swallowing ☐ Depression ☐ Anxiety ☐ Other: _____
Respiratory	☐ Shortness of breath/difficulty breathing: ☐ at rest ☐ with activity ☐ when lying down ☐ Cough ☐ Wheezing ☐ Other: _____
Cardiovascular	☐ Chest pain/pressure at rest ☐ Chest pain/pressure with activity ☐ Leg cramping with activity ☐ Fluid retention ☐ Palpitations ☐ Use of blood thinners (which one _____) ☐ Other: _____
Gastrointestinal	☐ Abdominal bloating/fullness ☐ Abdominal tenderness ☐ Cramping ☐ Belching ☐ Constipation ☐ Diarrhea ☐ Incontinence ☐ Flatulence ☐ Stools, black/bloody ☐ Hiccoughing ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Vomiting blood ☐ Other: _____
Genitourinary	☐ Burning ☐ Frequency ☐ Urgency ☐ Hesitancy ☐ Waking up to void at night ☐ Dribbling ☐ Pain ☐ Incontinence ☐ Blood in urine ☐ Abnormal Vaginal Bleeding ☐ Decreased urine output ☐ Vaginal Discharge ☐ Kidney failure ☐ Other: _____
Neuromuscular	☐ Back pain ☐ Joint stiffness ☐ Joint swelling ☐ Leg pain ☐ Neck pain ☐ Numbness ☐ Tingling ☐ Muscle pain ☐ Poor range of motion ☐ Other: _____
Skin	☐ Change in skin color ☐ Itching ☐ Abnormal Bruising ☐ Rash ☐ Other: _____
Neurologic	☐ Concentration difficulties ☐ Confusion / disorientation ☐ Dizziness ☐ Drowsiness ☐ Faintness ☐ Memory problems ☐ Speech difficulties ☐ Visual changes ☐ Other: _____
Lymphatic	☐ Enlarged lymph nodes ☐ Swelling of extremity ☐ Heaviness of extremity ☐ Tightness/hardening of skin ☐ Other: _____