

MEDICAL SYMPTOMS CHECKLIST

PATIENT'S NAME: _____ Please list your current medications on the Medical List form provided in your packet. Be sure to spell correctly and list the dosage and amount of medication you are taking as listed on your prescription bottle. Bringing in your medications for our review would be greatly appreciated.

REVIEW OF SYSTEMS	Y	N		Y	N		Y	N
GENERAL			STOMACH			NEUROLOGICAL		
Headache			Trouble swallowing			Stroke		
Lethargy/Weakness			Heartburn/Indigestion			Seizures		
Chills/Night sweats			Change in bowel habits			Head injury		
Fever			Loose Stool/diarrhea			Memory loss		
Fainting spells/unconscious			Black/Bloody Stools			Confusion		
Weight loss			Frequent stomach pain			Trouble speaking		
Dizziness			Vomiting blood			Trouble swallowing		
EYES			Constipation			Unsteady gait		
Wears glasses			Irritable bowel			Trouble walking		
Eyesight worsening			Ulcers			Arm/leg weakness		
Double vision			Stomach/bowel cancer			Arm/leg tingling		
Eye pain			KIDNEY PROSTATE			Arm/leg numbness		
EARS/NOSE/THROAT			Frequent voiding			PSYCHIATRIC		
Deafness			Burning on urination			Nervous breakdown		
Noise in ears			Pus/blood in urine			Panic attacks		
Congestion/sneezing			Trouble starting urination			Cry often/depressed		
Sinus trouble/hay fever			Dribble with cough/sneeze			Worry a lot		
Nose bleeds			Loss of urine control			Considered suicide		
Sore throat or tongue			Prostate disease/cancer			Loss of interest in eating		
Hoarse voice			Sexual difficulty			Anxiety/tension		
Dental problem			SKIN			Loss of energy/fatigue		
HEART			Rashes			ENDOCRINE		
Chest pain with exertion			Birthmarks			Unwanted weight change		
Heart attack			Sores			Change in skin		
Heart murmur			Dry/oily skin			Breast discharge		
Heart racing/palpitations			Hair growth/loss			Excessive thirst		
Irregular heart beat			MUSCLE/BONE			Excessive tiredness		
Mitral valve prolapsed			Back pain			BREAST/MENSTRUAL		
High blood pressure			Neck pain			Endometriosis		
Swollen feet/ankles			Back surgery			Are you pregnant?		
Heart valve replacement			Arthritis			Irregular menstrual period		
Atrial fibrillation			Fibromyalgia			Breast discharge		
LUNG			Aching muscles/joints			Lumps in breast		
Lung cancer			Shoe lift or brace			SLEEP		
Shortness of breath			Bone/joint injury			Dreams/sleep walk		
Chest pain			Osteoporosis			Legs twitch		
Coughing up phlegm			HETATOLOGIC			Insomnia		
Cough up blood			Blood disease			Daytime drowsiness		
Wheezing/cough			Enlarged glands			Snoring		
Pneumonia			Bleed/bruise easily			Breath holding/gasping		
			Anemia/low blood			Restless sleep		

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