

5. Please check all symptoms you have experienced in the last MONTH:

- | | | |
|---|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Lump in your throat | <input type="checkbox"/> Paralysis of arms or legs |
| <input type="checkbox"/> Weight gain (>10 lbs) | <input type="checkbox"/> Cough | <input type="checkbox"/> Numbness or tingling of arms or legs |
| <input type="checkbox"/> Weight loss (<10 lbs) | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fainting spells |
| <input type="checkbox"/> Feeling sickly | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Swelling of hands |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain in the chest | <input type="checkbox"/> Swelling of ankles |
| <input type="checkbox"/> Unusual fatigue | <input type="checkbox"/> Heart pounding (palpitations) | <input type="checkbox"/> Swelling of other joints |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Heartburn or stomach gas | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Skin rash or hives | <input type="checkbox"/> Stomach pain or cramps | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Unusual bruising or bleeding | <input type="checkbox"/> Nausea | <input type="checkbox"/> Use of drugs not sold in stores |
| <input type="checkbox"/> Other skin problems | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Smoking cigarettes |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Constipation | <input type="checkbox"/> More than 2 alcoholic drinks per day |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Depression - feeling blue |
| <input type="checkbox"/> Other eye problems | <input type="checkbox"/> Dark or bloody stools | <input type="checkbox"/> Anxiety - feeling nervous |
| <input type="checkbox"/> Problems with hearing | <input type="checkbox"/> Problems with urination | <input type="checkbox"/> Problems with thinking |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Gynecological (female) problems | <input type="checkbox"/> Problems with memory |
| <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Problems with sleeping |
| <input type="checkbox"/> Sores in the mouth | <input type="checkbox"/> Losing your balance | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Muscle pain, aches or cramps | <input type="checkbox"/> Burning in sex organs |
| <input type="checkbox"/> Problems with smell or taste | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Problems with social activities |

**FOR OFFICE
USE ONLY**

5. ROS:

6. Please list any changes in your health, medications, occupation or medical care since your last visit:

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____