Symptom Checklist

Name ___________________________  MRN# ___________________________
Date ___________________________

Please review the following list of medical symptoms and circle each symptom that you experience or have a history of. If necessary please explain in detail below each category.

Constitutional – fever, weight loss, weight gain, nights sweats

Eyes – blurred vision, dry eyes, double vision, loss of vision

Cardiovascular – heart disease, chest pain, palpitations, swelling of the feet and legs

Respiratory – asthma, COPD, difficulty breathing, shortness of breath

Gastrointestinal – abdominal pain, diarrhea, constipation, bloody stools

Genitourinary – painful urination, blood in the urine, frequent urination, sexual dysfunction
Musculoskeletal – joint pain, muscle pain

Skin – rashes, bites

Neurological – seizures, headaches, dizziness, falls, incoordination, numbness, tingling, back pain, neck pain, weakness, difficulty walking, stroke

Psychiatric – depression

Endocrine – intolerant to heat, cold, thyroid dysfunction

Hematologic – easy bruising, bleeding

Allergy – seasonal or environmental allergies