

## RECENT SYMPTOM QUESTIONNAIRE

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Have you have any of the following symptoms in the past two months? Write comments if you like.

### GENERAL

- |                             |                              |                             |
|-----------------------------|------------------------------|-----------------------------|
| fatigue                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| unexplained recurring fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| night sweats                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| unexplained weight gain     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| unexplained weight loss     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### EAR, NOSE & THROAT

- |                                  |                              |                             |
|----------------------------------|------------------------------|-----------------------------|
| ear pain                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| hearing difficulty or deafness   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ringing in ears                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| frequent nose bleeds             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| nasal congestion/sinus problems  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| bleeding gums                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| chronic hoarseness               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| chronic sores in mouth or throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| seasonal or year long allergies  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### HEART (CARDIOVASCULAR)

- |                                      |                              |                             |
|--------------------------------------|------------------------------|-----------------------------|
| chest pains or pressure              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| pains in the lower legs from walking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| trouble breathing with walking       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| irregular heart beats                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| trouble breathing laying flat        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| lower leg swelling                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| racing heart                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### LUNGS (PULMONARY)

- |                              |                              |                             |
|------------------------------|------------------------------|-----------------------------|
| chronic cough                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| shortness of breath          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| coughing up blood            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| pain in chest with breathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| wheezing                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### GASTROINTESTINAL

- |                                     |                              |                             |
|-------------------------------------|------------------------------|-----------------------------|
| abdominal pain                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| poor appetite                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| bloating or swelling of the abdomen | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| difficulty or pain with swallowing  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| constipation                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| diarrhea                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| indigestion or heartburn            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| vomiting blood                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| blood in stools                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| chronic nausea                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| stool caliber change                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### GENITOURINARY

- |                                 |                              |                             |
|---------------------------------|------------------------------|-----------------------------|
| pain or burning while urinating | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| genital lesions                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| blood in urine                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| difficulty controlling bladder  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| frequent nighttime urination    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| difficulty passing urine        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| sexual issues                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| breast lumps/changes            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| low sex drive                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### MUSCULOSKELETAL

- |                              |                              |                             |
|------------------------------|------------------------------|-----------------------------|
| painful joints               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| chronic back pain            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| chronic pain in arms or legs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| muscle aches                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### SKIN

- |                                 |                              |                             |
|---------------------------------|------------------------------|-----------------------------|
| changing shape or size of moles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| rash                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| easy bruising                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| easy bleeding                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| swollen glands                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### NEUROLOGIC

- |                          |                              |                             |
|--------------------------|------------------------------|-----------------------------|
| balance problems         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| dizzy spells             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| fainting                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| frequent headaches       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| memory loss              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| tremor                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| weakness in arms or legs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

### PSYCHIATRIC

- |                                    |                              |                             |
|------------------------------------|------------------------------|-----------------------------|
| anxiety                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| crying spells                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| depression                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| feeling stressed                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| loss of interest in fun activities | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| personality changes                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| poor concentration                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| sleeping problems                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| suicidal thoughts                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Other \_\_\_\_\_