

Review of Symptoms

Height _____ Weight _____ Weight 1 yr. ago _____

Please Circle the appropriate letter next to the item based on the following:

N = a condition you have now

P = a condition you have had in the past

Chest Pain	N	P	Allergies	N	P
Right/Left Arm Pain/ Tingling	N	P	Poor Appetite	N	P
Right/Left Leg Pain/Tingling	N	P	Excessive Thirst	N	P
Right/Left Foot Pain/Tingling	N	P	Diarrhea/Constipation	N	P
Right/Left Hand Pain/Tingling	N	P	Urinary Trouble	N	P
Fingers/Toes Pain/Tingling	N	P	Chest Pain	N	P
Dizziness/Vertigo	N	P	Short Breath	N	P
Vision Disturbance/Double Vision	N	P	Blood Pressure Problems	N	P
Movement Restriction	N	P	Lung Problems	N	P
Shooting pain	N	P	Stroke	N	P
Sleep Disruption	N	P	Heart Attack	N	P
Anxiety/Stress	N	P	Earaches	N	P
Headaches	N	P	Menstrual Problems	N	P
Head Injury	N	P	HIV / AIDS	N	P
Ear Ringing/Tinnitus	N	P	Cancer	N	P
Change in Taste	N	P	Diabetes	N	P
Asthma	N	P	Epilepsy	N	P
Nausea	N	P	Sinus Problems	N	P
Vomiting	N	P	Osteoporosis	N	P
Abdominal Pain	N	P	Liver Disease	N	P
Joint Pain/Stiffness	N	P	Kidney Stones	N	P
Arthritis	N	P	Depression	N	P
Muscle Weakness	N	P	Earaches/Ear Infections	N	P
Memory Loss	N	P	Heart Disease	N	P
Difficulty Sleeping	N	P	Allergies	N	P
Fainting	N	P	Ankle Swelling	N	P
Seizures	N	P	Menstrual Problems	N	P
Knee/Shoulder/Elbow/Wrist Pain	N	P	Deep Leg Pain	N	P
Jaw Pain	N	P	Thyroid Problem	N	P
Fatigue/Tiredness	N	P	Bronchitis	N	P
Headaches/Migraines	N	P	Pneumonia	N	P
Fibromyalgia	N	P	Prostate Disease	N	P
Abnormal skin sensation (numb)	N	P	Gall Stones	N	P

Any other health issues that we may need to know about: _____
