Name _____ DOB _____
Today's Date _____

Please note:

Providing the information below is important to your healthcare, however, there may not be sufficient time to address these issues at the same time as your annual exam. It may be appropriate to schedule an additional visit to focus on additional concerns.

Review of Symptoms: Please check any current **(within the last two weeks)** symptoms you have:

Constitutional	*Respiratory*	*Skin*
□ recent fevers/sweats	□ cough/wheeze	□ rash
□ unexplained weigh loss/gain	□ coughing up blood	□ new or change in mole
□ unexplained fatigue/weakness		
	Gastrointestinal	*Neurological*
Eyes	□ heartburn/reflux	□ headaches
□ change in vision	□ blood or change in bowel movement	□ memory loss
	□ nausea/vomiting/diarrhea	□ fainting
Ears/Nose/Throat/Mouth	□ pain in abdomen	
□ difficulty hearing/ringing in ears		*Psychiatric*
□ hay fever/allergies/congestion	*Genitourinary*	□ anxiety/stress
□ trouble swallowing	□ painful/bloody urination	□ sleep problem
	□ leaking urine/dribbling	□ depression
Cardiovascular	□ nighttime urination	
□ chest pains/discomfort	□ discharge: penis or vagina	*Blood/Lymphatic*
□ palpitations	□ unusual vaginal bleeding	□ unexplained lumps
□ short of breath with exertion	□ concern with sexual functions	□ easy bruising/bleeding
	□ achieving/maintaining erection	
Breast	*Musculoskeletal*	*Endo*
□ breast lump	□ muscle/joint pain	□ cold/heat intolerance
□ nipple discharge	□ recent back pain	□ increase thirst/appetite

Is there anything else we could do to improve your care? _____

_____