

Symptom Checklist



General <input type="checkbox"/> Weight loss or gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever/chills <input type="checkbox"/> Weakness <input type="checkbox"/> Trouble sleeping	Respiratory/Cardiac <input type="checkbox"/> Asthma <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest tightness <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Blue fingers/toes <input type="checkbox"/> Swelling of hands/feet <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beats <input type="checkbox"/> Heart murmur <input type="checkbox"/> History of heart attack <input type="checkbox"/> History of heart medication <input type="checkbox"/> Bronchitis/emphysema <input type="checkbox"/> Rheumatic heart disease <input type="checkbox"/> Sudden awakening gasping for air <input type="checkbox"/> Shortness of breath with walking <input type="checkbox"/> History of pacemaker/defibrillator <input type="checkbox"/> History of pulmonary embolism	Peripheral Vascular <input type="checkbox"/> Leg cramps <input type="checkbox"/> Calf pain when walking <input type="checkbox"/> History of deep vein thrombosis <input type="checkbox"/> History of vascular surgery <input type="checkbox"/> History of Port placement
Skin <input type="checkbox"/> Rash <input type="checkbox"/> Itching <input type="checkbox"/> Dryness <input type="checkbox"/> Color changes <input type="checkbox"/> Hair/nail changes	Gastrointestinal <input type="checkbox"/> Change in weight or appetite <input type="checkbox"/> Problem swallowing <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Changes in bowel habits <input type="checkbox"/> Heartburn/reflux <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Excessive belching <input type="checkbox"/> Excessive flatus (gas) <input type="checkbox"/> Food intolerances <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> History of hernia <input type="checkbox"/> History of liver failure <input type="checkbox"/> History of Hepatitis	Musculoskeletal <input type="checkbox"/> Muscle pain <input type="checkbox"/> Swelling of joints <input type="checkbox"/> Stiffness of joints <input type="checkbox"/> Decreased joint motion <input type="checkbox"/> Broken bones <input type="checkbox"/> Arthritis <input type="checkbox"/> Gout <input type="checkbox"/> Trauma
Head <input type="checkbox"/> Headaches/migraines <input type="checkbox"/> Head injuries	Urinary <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Pain/burning on urination <input type="checkbox"/> Frequent urination at night <input type="checkbox"/> Urgent need to urinate <input type="checkbox"/> Dribbling <input type="checkbox"/> Incontinence <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Urinary tract infections (now/recurrent) <input type="checkbox"/> History of kidney failure	Spine <input type="checkbox"/> Neck pain <input type="checkbox"/> Back pain <input type="checkbox"/> Previous spinal surgeries
Ears <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Earaches <input type="checkbox"/> Drainage <input type="checkbox"/> Hearing aids	Breast <input type="checkbox"/> Lumps <input type="checkbox"/> Pain <input type="checkbox"/> Discharge <input type="checkbox"/> History of breast cancer/surgery <input type="checkbox"/> Breast feeding	Neurologic <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness (or pins/needles) <input type="checkbox"/> Tremor <input type="checkbox"/> Involuntary movements <input type="checkbox"/> Muscle spasms <input type="checkbox"/> History of stroke/transient ischemic attack <input type="checkbox"/> History of concussions <input type="checkbox"/> History of traumatic brain injury <input type="checkbox"/> Paralysis <input type="checkbox"/> Loss of muscle strength/size <input type="checkbox"/> History of brain mass <input type="checkbox"/> History of brain surgery
Eyes <input type="checkbox"/> Vision loss/changes <input type="checkbox"/> Glasses/contacts <input type="checkbox"/> Pain <input type="checkbox"/> Redness <input type="checkbox"/> Blurred or double vision <input type="checkbox"/> Flashing lights <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Yellow eyes/skin <input type="checkbox"/> Last eye exam: _____	Past Surgeries/Implants: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Hematologic <input type="checkbox"/> Anemia <input type="checkbox"/> Easy bruising/bleeding <input type="checkbox"/> Past transfusions <input type="checkbox"/> Known clotting disorders <input type="checkbox"/> Known bleeding disorders
Nose <input type="checkbox"/> Stuffiness <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Itching <input type="checkbox"/> Hay fever <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Sinus pain <input type="checkbox"/> Past surgeries: _____	Endocrine <input type="checkbox"/> Hot/cold intolerance <input type="checkbox"/> Sweating <input type="checkbox"/> Frequent urination <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Change in appetite <input type="checkbox"/> Thyroid dysfunction <input type="checkbox"/> Diabetes	
Mouth/Throat <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Dentures <input type="checkbox"/> Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Thrush <input type="checkbox"/> Non-healing sores <input type="checkbox"/> Dry mouth		
Neck <input type="checkbox"/> Lumps <input type="checkbox"/> Goiter <input type="checkbox"/> Swollen glands <input type="checkbox"/> Stiffness <input type="checkbox"/> Pain		