

Patient's Name: _____

		Yes	No	Comments
Constitutional	Fever	<input type="checkbox"/>	<input type="checkbox"/>	
	Chills	<input type="checkbox"/>	<input type="checkbox"/>	
	Sweats	<input type="checkbox"/>	<input type="checkbox"/>	
	Weight loss	<input type="checkbox"/>	<input type="checkbox"/>	
	Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>	
	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	Painful breathing	<input type="checkbox"/>	<input type="checkbox"/>	
	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	
	Productive cough	<input type="checkbox"/>	<input type="checkbox"/>	
	Dry cough	<input type="checkbox"/>	<input type="checkbox"/>	
	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	
	Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	
	Dark or bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	
	Frequent constipation or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	
	Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
	Incomplete emptying	<input type="checkbox"/>	<input type="checkbox"/>	
	Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	
	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	
	Urinary urgency	<input type="checkbox"/>	<input type="checkbox"/>	
	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
	Urinary Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
	Getting up at night to urinate	<input type="checkbox"/>	<input type="checkbox"/>	
	Bleeding or pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>	
	Unusual discharge or odor	<input type="checkbox"/>	<input type="checkbox"/>	
Vulvar or vaginal itching or burning	<input type="checkbox"/>	<input type="checkbox"/>		
Allergy/Immuno	Pelvic Pain	<input type="checkbox"/>	<input type="checkbox"/>	
	Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	
	Itching eyes or nose	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	Hives	<input type="checkbox"/>	<input type="checkbox"/>	
	Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	
	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	
	Joint pain, stiffness	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	Swelling of legs	<input type="checkbox"/>	<input type="checkbox"/>	
	Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>	
	Double vision	<input type="checkbox"/>	<input type="checkbox"/>	
Ears, Nose, Throat	Ear aches	<input type="checkbox"/>	<input type="checkbox"/>	
	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	
	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	
	Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiac	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	
	Shortness of breath at rest	<input type="checkbox"/>	<input type="checkbox"/>	
	Shortness of breath w/mild exertion	<input type="checkbox"/>	<input type="checkbox"/>	
	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	
	Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	
	Palpitation	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic	Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	Nodules	<input type="checkbox"/>	<input type="checkbox"/>	
	Change in moles, freckles	<input type="checkbox"/>	<input type="checkbox"/>	
	Change in hair growth, loss, texture	<input type="checkbox"/>	<input type="checkbox"/>	
	Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>	
	Breast nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	
	Breast pain	<input type="checkbox"/>	<input type="checkbox"/>	
Heme/Lymph	Swollen lymph glands	<input type="checkbox"/>	<input type="checkbox"/>	
	Easy bruisability	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	
	Tremor	<input type="checkbox"/>	<input type="checkbox"/>	
	Cold or heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	
	Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	
Psych	Depression	<input type="checkbox"/>	<input type="checkbox"/>	
	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	