Review of Symptoms

Today's Date: _____ Patient Name: _____ Date of Birth: _____

Please review and mark any current symptoms or problems you have experienced in the last six months.

General:
☐Loss of appetite
☐Fever/chills
☐Night sweats
☐Weakness
☐Fatigue

Hematologic:
☐Abnormal bleeding
☐Abnormal bruising
☐Swollen glands

Allergies/immunologic:
☐Seasonal allergies
☐Food allergy_____
☐Sinus Problems
☐Frequent infections

Skin:
☐Slow healing
☐Rash
☐Nail change
☐Change in skin or mole
☐Other _____

Breasts:
☐Discharge/bleeding
☐Lump
☐Pain

Eyes:
☐Change in vision
☐Eye infection
☐Eye pain

Ears/Nose/Throat:
☐Hearing loss
☐Ringing in ears
☐Bleeding gums
☐Hoarseness
☐Neck swelling/lumps
☐Nose bleeds
☐Dental Issues

Cardiovascular:
☐Chest discomfort/pain
☐Irregular heart beat
☐Swollen hands or feet
☐Racing heart

Respiratory:
☐Shortness of breath
☐Cough
☐Wheezing
☐Cough up blood
☐Difficulty breathing

Gastrointestinal:
☐Bloody or black stools
☐Constipation
☐Difficulty swallowing
☐Heartburn/esophageal reflux
☐Diarrhea
☐Nausea
☐Vomiting
☐Abdominal Pain
☐Pain with bowel movements
☐Jaundice

Urinary:
☐Blood in urine
☐Frequency
☐Difficulty urinating
☐Pain or burning with urination
☐Incontinence

Musculoskeletal:
☐Back or neck pain
☐Painful or stiff joints
☐Bone pain, Site: _____
☐Arthritis

Mental Health:
☐Depressed or sad
☐Anxiety
☐Sleep issues
☐Suicidal thoughts

Neurological:
☐Headaches
☐Dizziness
☐Fainting
☐Loss of balance
☐Difficulty speaking
☐Loss of sensation
☐Memory Issues
☐Seizures

Endocrine:
☐Weight loss
☐Weight gain
☐Excessive thirst
☐Heat/cold intolerance

FOR WOMEN
Gynecological:
☐Irregular menstrual periods
☐Hot flashes
☐Menopause
☐Heavy menstrual bleeding

Check this box if you do ***NOT* have any symptoms listed:**

☐I do **not** have any symptoms.

Reviewed/Approved, OCM Quality Committee, May 2017, updated 2/12/2026