

Print Patient Name		Date:		Pt ID#:	
---------------------------	--	--------------	--	----------------	--

Please check the appropriate boxes indicating the symptoms you are CURRENTLY experiencing.

Constitutional	<input type="checkbox"/> Frequently Tired	<input type="checkbox"/> Fever	<input type="checkbox"/> Chills
	<input type="checkbox"/> Body Aches	<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Weight Loss
	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Swelling in Armpits or Groin

Cardiovascular	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Irregular Heart Beats	<input type="checkbox"/> Rapid Heart Rate
	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Difficulty Breathing on Exertion	<input type="checkbox"/> Discomfort Breathing - Lying
	<input type="checkbox"/> Shortness of Breath at Night (laying down)	<input type="checkbox"/> Lower Extremity Swelling	<input type="checkbox"/> Bluish Color to Skin
	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Limp in Walk	<input type="checkbox"/> Abnormal Sensation - Standing Fainting
	<input type="checkbox"/> Tightness	<input type="checkbox"/> Heart Thumping/Racing	

Respiratory	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Phlegm
	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Abnormal Sputum Production	<input type="checkbox"/> Coughing up blood
	<input type="checkbox"/> Cough		

Gastrointestinal	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea
	<input type="checkbox"/> Constipation	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Heartburn
	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Excessive Belching	<input type="checkbox"/> Abdominal pain
	<input type="checkbox"/> Blood in Stools	<input type="checkbox"/> Black Tarry Stool	<input type="checkbox"/> Hemorrhoids
	<input type="checkbox"/> Excessive Flatulence	<input type="checkbox"/> Bloating	<input type="checkbox"/> Irregular Bowels

Neurologic	<input type="checkbox"/> Muscular Weakness	<input type="checkbox"/> Incoordination	<input type="checkbox"/> Tingling or Numbness
	<input type="checkbox"/> Difficulty Concentrating	<input type="checkbox"/> Memory Difficulties	<input type="checkbox"/> Speech Difficulties
	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tremors	<input type="checkbox"/> Loss of Balance

Endocrine	<input type="checkbox"/> Excessive Urination	<input type="checkbox"/> Excessive or Abnormal Thirst	<input type="checkbox"/> Excessive Breast Milk
	<input type="checkbox"/> Loss of Hair	<input type="checkbox"/> Constipation	<input type="checkbox"/> Cold Intolerance
	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Decreased Libido	<input type="checkbox"/> Central Obesity
	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Acne

Psychiatric	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Hallucinations
	<input type="checkbox"/> Feeling Confused	<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Compulsive Behaviors
	<input type="checkbox"/> Suicidal Ideation	<input type="checkbox"/> Excessive Anger	<input type="checkbox"/> I Feel Unhappy
	<input type="checkbox"/> I Have No Energy	<input type="checkbox"/> Sleeping Too Much	<input type="checkbox"/> Sleeping Too Little
	<input type="checkbox"/> I Feel Sluggish/Restless	<input type="checkbox"/> I Feel Helpless About Future	

Heme-Lymph	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Easy Bruising
	<input type="checkbox"/> Purple Spots on Skin	<input type="checkbox"/> Lymph Node Enlargement or Tenderness	

Allergic-Immunologic	<input type="checkbox"/> Sinus Allergy Symptoms	<input type="checkbox"/> Allergic Skin Inflammation	<input type="checkbox"/> Frequent Illnesses
-----------------------------	---	---	---