Patient Name: _____ Date of Birth: _____

General/Constitutional		
Fatigue or loss of energy	O No	O Yes
Fever	O No	O Yes
Weight loss	O No	O Yes
Allergy/Immunology		
Rash	O No	O Yes
Seasonal allergies	O No	O Yes
Nasal congestion	O No	O Yes
ENT		
Hoarseness	O No	O Yes
Difficulty swallowing	O No	O Yes
Sinus headache	O No	O Yes
Endocrine		
Cold intolerance	O No	O Yes
Thyroid problems	O No	O Yes
Heat intolerance	O No	O Yes
Respiratory		
Cough	**O** Non-productive or **O** Productive	O No cough
Wheezing	O No	O Yes
Sputum production	O No O Yes	O with blood
Cardiovascular		
Awakening due to Shortness of breath	O No	O Yes
Chest pain with exertion	O No	O Yes
Shortness of Breath on exertion	O No	O Yes
Gastrointestinal		
Change in bowel habits	O No O Constipation	O diarrhea
Decreased appetite	O No	O Yes
Heartburn	O No O Yes	O controlled with meds
Hematology		
Blood clots	O No	O Yes
Swollen glands	O No	O Yes
Breast lump	O No	O Yes
Genitourinary		
Frequent urination	O No	O Yes
Difficulty urinating	O No	O Yes
Musculoskeletal		
Arthritis	O No	O Yes
Back problems or pain	O No	O Yes
Neurologic		
Headache	O No	O Yes
Memory loss	O No	O Yes
Psychiatric		
Mood swings	O No	O Yes
Difficulty sleeping	O No	O Yes

Have you had a Pneumonia Vaccine: Yes /No Date of last One: _____ Administered by_____
Have you had a Flu Vaccine Yes / No Date of last One: _____ Administered by _____