

Are you currently having any problems related to the following systems? Check Yes or No

General

- Feeling well Yes No
- Weight loss/gain Yes No
- Fatigue Yes No
- Fever Yes No

Integumentary (skin)

- New or changing moles Yes No
- Itching Yes No
- Rash Yes No

HEENT

- Eye pain Yes No
- Change in vision/vision loss Yes No
- Change in/difficulty hearing Yes No
- Ear pain Yes No
- Runny nose Yes No
- Difficulty swallowing Yes No

Respiratory

- Cough Yes No
- Snoring Yes No
- Difficulty breathing Yes No

Breast

- Breast lumps Yes No
- Breast pain Yes No
- Nipple discharge Yes No

Cardiovascular

- Chest pain Yes No
- Palpitations Yes No
- Waking at night with difficulty breathing Yes No
- Swelling in legs Yes No

Gastrointestinal

- Abdominal pain Yes No
- Black or bloody stool Yes No
- Constipation Yes No
- Diarrhea Yes No
- Heartburn/indigestion Yes No
- Nausea/vomiting Yes No

Genitourinary

- Difficulty starting stream Yes No
- Impotence Yes No
- Urine loss/leakage Yes No
- Awaken at night to urinate Yes No
- Difficulty emptying bladder completely Yes No

Musculoskeletal

- Back pain Yes No
- Joint pain Yes No
- Have you given up any activity due to pain? Yes No

Neurological

- Numbness/tingling Yes No
- Difficulty speaking Yes No
- Headaches Yes No

Psychological

- Difficulty with sleep Yes No
- Anxiety Yes No
- Depression Yes No

Endocrine

- Excessive thirst Yes No
- Heat/cold intolerance Yes No

Hematology

- Easy Bruising/nosebleeds Yes No

Name _____

Date _____