Current Symptom Review

Rate average energy past week (1=low, 10= high): _____/10

	Symptoms		No Problem	Issue details: circle one N =new, C = chronic. → **Please provide details /changes.**
a)	Fevers/ Sweats	a)		N / C →
b)	Intolerance of cold	b)		N / C →
c)	Intolerance of heat	c)		N / C →
d)	Vision change	d)		N / C →
e)	Sinus or ear symptoms	e)		N / C →
f)	Chest Pains	f)		N / C →
g)	Heart Racing	g)		N / C →
h)	Leg swelling (edema)	h)		N / C →
i)	Shortness of breath	i)		N / C →
j)	Cough	j)		N / C →
k)	Nausea or Vomiting	k)		N / C →
l)	Abdominal Pain	l)		N / C →
m)	Discomfort w/ urination	m)		N / C →
n)	Joint Pains	n)		N / C →
o)	Balance problems / Falls	o)		N / C →
p)	Difficulty with memory	p)		N / C →
q)	Tremor	q)		N / C →
r)	Headaches	r)		N / C →
s)	Skin rash or skin lesions	s)		N / C →
t)	Hair Loss	t)		N / C →
u)	Bleeding / Bruising	u)		N / C →
v)	Allergies	v)		N / C →
w)	Insomnia	w)		N / C →
x)	Anxiety	x)		N / C →
y)	Depression	y)		N / C →
z)	Men:Erectile dysfunction	z)		N / C →
	Women: Menstrual change			N / C →

Bowel Movements: Per day _____ OR Per week _____

Urinating at night: none OR # per night _____

Alcohol Consumption: Drinks per day: _____ or per week:_____ Other: _____

Smoking: Packs per day: _____ or per week: _____ Never: _____