

Name: _____ Today's Date: _____

****Please check the boxes if you have been experiencing any of the problems/symptoms listed below within the last 48 hours****

Gastrointestinal:

- | | | | |
|--|---|---|---------------------------------------|
| <input type="checkbox"/> nausea | <input type="checkbox"/> vomiting | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> constipation |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> blood in stool | <input type="checkbox"/> heartburn | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> incontinence of stool | <input type="checkbox"/> no problems | | |

General:

- | | | | |
|--|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> fever | <input type="checkbox"/> chills | <input type="checkbox"/> sweats | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> weight loss | <input type="checkbox"/> nasal congestion | <input type="checkbox"/> hoarseness | |
| <input type="checkbox"/> dental problems | <input type="checkbox"/> nose bleeding | <input type="checkbox"/> no problems | |

Genitourinary:

- | | | |
|--|--|---|
| <input type="checkbox"/> pain/burning when urinating | <input type="checkbox"/> blood in urine | <input type="checkbox"/> increased frequency of urination |
| <input type="checkbox"/> incomplete voiding | <input type="checkbox"/> incontinence of urine | <input type="checkbox"/> menstruation irregularity |
| <input type="checkbox"/> menopause | <input type="checkbox"/> pregnancy | <input type="checkbox"/> irritable bowel syndrome |
| <input type="checkbox"/> no problems | | |

Heart:

- | | | | |
|--|---------------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> chest pain | <input type="checkbox"/> palpitations | <input type="checkbox"/> racy heart | <input type="checkbox"/> leg swelling |
| <input type="checkbox"/> pain when walking | <input type="checkbox"/> no problems | | |

Hematological:

- bleeding/clotting disturbance no problems

Lungs:

- | | | | |
|-----------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> coughing | <input type="checkbox"/> blood in cough | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> no problems |
|-----------------------------------|---|--|--------------------------------------|

Lymphatic:

- swollen lymph nodes no problems

Muscle & Joints:

- | | | | |
|---------------------------------------|--------------------------------------|--|----------------------------------|
| <input type="checkbox"/> muscle aches | <input type="checkbox"/> joint pains | <input type="checkbox"/> joint swelling. | <input type="checkbox"/> sprains |
| <input type="checkbox"/> cramps | <input type="checkbox"/> no problems | | |

Neurological:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> fits | <input type="checkbox"/> faints | <input type="checkbox"/> blackouts | <input type="checkbox"/> pins & needles |
| <input type="checkbox"/> numbness | <input type="checkbox"/> weakness | <input type="checkbox"/> nervousness | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> depression | <input type="checkbox"/> gait problems | <input type="checkbox"/> tremors | <input type="checkbox"/> shaking |
| <input type="checkbox"/> speech problems | <input type="checkbox"/> swallowing problems | <input type="checkbox"/> ringing & buzzing in the ears | |
| <input type="checkbox"/> vision problems | <input type="checkbox"/> hearing problems | <input type="checkbox"/> neck pain | <input type="checkbox"/> back pain |
| <input type="checkbox"/> memory problems | <input type="checkbox"/> headache/migraine | <input type="checkbox"/> cold feet | <input type="checkbox"/> no problems |

Sleep:

- | | | |
|---|--|---|
| <input type="checkbox"/> lack of sleep | <input type="checkbox"/> inability to fall asleep | <input type="checkbox"/> inability to stay awake |
| <input type="checkbox"/> tiredness/sleepiness during the day | <input type="checkbox"/> snoring at night | <input type="checkbox"/> choking at night |
| <input type="checkbox"/> holding breath at night | <input type="checkbox"/> acting on dreams at night | <input type="checkbox"/> restless legs before sleeping |
| <input type="checkbox"/> funny/creepy crawly feelings in the legs before sleeping | | <input type="checkbox"/> PAP machine <input type="checkbox"/> no problems |