Name: _____ Date: _____

SYSTEM REVIEW *Please check if you are experiencing any of the following symptoms and sign below.*

GENERAL:
□ Yes □ No……Fatigue
□ Yes □ No……Generalized weakness
□ Yes □ No……Fever
□ Yes □ No……Chills
□ Yes □ No……Night sweats
□ Yes □ No……Trouble sleeping
□ Yes □ No……Unintentional weight loss
□ Yes □ No……Significant weight gain

SKIN:
□ Yes □ No……Rashes
□ Yes □ No……Lesions
□ Yes □ No……Sores
□ Yes □ No……Bruising
□ Yes □ No……Itching
□ Yes □ No……Nail changes

HEAD:
□ Yes □ No……Vision changes
□ Yes □ No……Hearing loss
□ Yes □ No……Ringing ears
□ Yes □ No……Nose bleeds
□ Yes □ No……Dry mouth
□ Yes □ No……Hoarseness
□ Yes □ No……Frequent sore throats

HEART/CIRCULATION:
□ Yes □ No……Heart palpitations
□ Yes □ No……Pain in legs when walking
□ Yes □ No……Shortness of breath when lying flat
□ Yes □ No……Swollen ankles

LUNGS:
□ Yes □ No……Shortness of breath
□ Yes □ No……Cough
□ Yes □ No……Sputum/mucus production
□ Yes □ No……Coughing up blood
□ Yes □ No……Wheezing

BREASTS:
□ Yes □ No……Lumps/masses
□ Yes □ No……Nipple discharge
□ Yes □ No……Pain
□ Yes □ No……Skin changes

ENDORCRINE:
□ Yes □ No……Heat intolerance
□ Yes □ No……Cold intolerance
□ Yes □ No……Excessive thirst
□ Yes □ No……Excessive hunger