Name____ DOB____________________ Date________________

Please circle any symptoms you have had within the past 30 days

Constitutional

Weight loss

Fatigue

Ear/Nose/Throat

Foreign body sensation

Hoarseness

Cardiac

Chest pain

Palpitations

Respiratory

Cough
Shortness of breath

Gastrointestinal

Nausea

Vomiting

Vomiting blood

Pain with Swallowing

Difficulty swallowing

Heartburn

Diarrhea

Poor appetite

Abdominal pain

Gas or bloating

Constipation

Hemorrhoids

Rectal Bleeding

Black tarry stool

Rectal or anal pain

Anal itching

Jaundice

Genitouriary

Urinary incontinence

Musculoskeletal

Joint pain

Back pain

Dermatologic

Rash

Neurological

Mental status change

Psychiatric

Depression
Anxiety

Hematologic/Lymphatic

Abnormal bleeding and bruising

If no symptoms, please check here ☐

Have you had any medication change? Yes/No

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Have you had a Flu vaccine? Yes/ No

Date: ____________________

Have you had a Pneumonia vaccine? Yes/ No

Date:____________________