Current Symptoms

Patient Name: _____ DOB: _____

Please check in the box any symptoms you are **CURRENTLY** experiencing.
Or new symptoms you have had **within the past 2 weeks**

Weight Change	☐	Headache	☐	Coughing Blood	☐
Change in Appetite	☐	Numbness	☐	Shortness of Breath at Rest	☐
Fatigue	☐	Tingling	☐	Shortness of Breath with Activity	☐
Fever	☐	Tremor	☐	Wheezing	☐
Ear Pain/Pressure	☐	Seizure	☐	Heartburn or Regurgitation	☐
Ringing in Ears	☐	Memory Loss	☐	Nausea/Vomiting	☐
Loss of Hearing	☐	Fainting/Loss of Consciousness	☐	Abdominal Pain	☐
Sinus Pain	☐	Balance Problems	☐	Yellowing of Skin	☐
Post-nasal Drip/Congestion	☐	Change in or painful Walking	☐	Change in Bowel Habits	☐
Snoring	☐	Change in Speech	☐	Diarrhea	☐
Mouth or Tongue Sores	☐	Change in Smell or Taste	☐	Constipation	☐
Hoarseness	☐	Easy Bruising	☐	Change in Stool Color	☐
Difficulty Swallowing	☐	Joint Pain	☐	Change in Urine Color or Odor	☐
Sore Throat	☐	Joint Swelling	☐	Problems with urination	☐
Swollen Glands	☐	Joint Stiffness	☐	Suicidal thoughts	☐
Eye Irritation/itching/drainage	☐	Muscle Ache/pain	☐	Eating Disorder	☐
Excessive Tearing	☐	Increased Irritability	☐	Anxiety	☐
Eye Pain	☐	Difficulty Concentrating	☐	Panic Attacks	☐
Change in Vision	☐	Mood Changes	☐	High Stress Level	☐
Excessive Thirst	☐	Depression	☐	Sleep Disturbance	☐
Skin Issues	☐	Excessive Urination	☐	Sexual performance issues	☐
Hair Loss	☐	Excessive Sweating	☐	Genital rash/Penis discharge	☐
Excessive Body Odor	☐	Intolerance to Cold or Heat	☐	Testicular Pain/swelling/lump	☐
Hives	☐	Chest Pressure or Pain	☐	Menstrual Problems	☐
Acne	☐	Palpitations	☐	Vaginal Discharge/Itching	☐
Change in Mole	☐	Swelling in the Legs	☐	Problems w/Intercourse	☐
Changes in Skin Color or Texture	☐	Pain in Legs with Walking	☐	Pelvic Pain	☐
Problem w/ Nails	☐	Cold Hands/Feet	☐	Hot Flashes	☐
Difficulty with Wound Healing	☐	Cough	☐	Breast Problems	☐

Nurses: for Pediatric Wellness exams, verbally ask
patient/parent Developmental questions in ROS