Please Circle any of the following items that you have experienced in the last three months:

**CONSTITUTIONAL:** Normal
- Unintentional weight gain
- Unintentional weight loss
- Fever
- Chills

**EYES:** Normal
- Vision change
- Blurred vision

**ENT:**
- **Ears:** Normal
  - Difficulty hearing
  - Earache
- **Nose:** Normal
  - Nasal passage blockage (stuffiness)
  - Nosebleeds
  - Nasal discharge
- **Throat:** Normal
  - Hoarseness
  - Sore throat, sudden onset

**CARDIOVASCULAR:** Normal
- Palpitations
- Known heart murmur
- Chest pain
- Fainting (syncope)

**RESPIRATORY:** Normal
- Cough
- Wheezing
- Shortness of breath

**GASTROINTESTINAL:** Normal
- Abdominal pain
- Vomiting
- Nausea
- Frequent diarrhea
- Constipation

**GENITOURINARY:** Normal
- Pain during urination (dysuria)
- Hematuria
- Pain in the flank
- Urinary loss of control

**MUSCULOSKELETAL:** Normal
- Muscle Weakness
- Arthralgias/joint pain
- Stiffness
- Swelling

**INTEGUMENTARY:**
- **SKIN:** Normal
  - Rash
  - Wound
  - Growths/lesions
  - Slow to heal

**NEUROLOGIC:** Normal
- Dizziness
- Tingling
- Abnormality of walk
- Gait Change

**PSYCHIATRIC:** Normal
- Sleep disturbances
- Depression
- Nervousness
- Anxiety

**ENDOCRINE:** Normal
- Excessive thirst/water consumption (polydipsia)
- Temperature intolerance

**HEMATOLOGIC/LYMPHATIC:** Normal
- Easy bruising
- Excessive bleeding

**ALLERGIC/IMMUNOLOGIC:** Normal
- Complaint of allergic reaction