

Fill prior to each visit



NAME

Date

Since the last visit, did you have any of the following problems?

If the answer is Yes, please give a detailed description of the problem. If this is not a new problem, please tell us whether it became better or worse since the last visit.

General: Fever, Chills, Night sweats, Weight loss

If Yes, Describe and/or Compare

Fatigue Scale 0 (no fatigue) 1 2 3 4 5 6 7 8 9 10 (worst ever)

How active are you? Compared to the last visit, have any of the following changed?

Can you do more or less without getting very tired?

How much time do you spend resting?

Are you able to do your shopping, cooking, cleaning?

Do you take walks?

Do you exercise?

Please describe and/or compare

Are you in pain? If yes, please grade the pain on the scale from 0 to 10, describe pain quality (see below)

Pain Scale: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst ever)

Quality (mark all that apply): constant, intermittent, burning, crampy

Is it better or worse since your last visit?

Has your need for pain medications change? Yes No

Skin: Rashes, Itching, Dryness, Cracking, Color changes

If Yes, Describe and/or Compare

Ears, Nose, Throat Hearing problems, Ringing in the ears, Visual changes, Sore throat, Mouth sores, Hoarseness, Sinus problems, Running nose

If Yes, Describe and/or Compare

Respiratory: Cough, Wheezing, Shortness of breath, Blood in the sputum

If Yes, Describe and/or Compare

Cardiovascular: Chest pain, Palpitations, Swelling of the limbs or abdomen

If Yes, Describe and/or Compare

Gastrointestinal: Trouble swallowing, heartburn, abdominal pain, diarrhea, constipation, stool changes

If Yes, Describe and/or Compare

Urologic: Pain on urination, Urinary frequency, Excessive urination during the night, Straining on urination, Blood in the urine

If Yes, Describe and/or Compare

Gynecologic: Bleeding, vaginal discharge, dryness, pain during intercourse, other

If Yes, Describe and/or Compare

Breasts: skin changes, nipple changes, nodules/masses, pain

If Yes, Describe and/or Compare

Musculoskeletal: Joint pain, Bone pain, Back pain, Muscle pain or weakness

If Yes, Describe and/or Compare

Neurologic: Headache, Numbness, "Pins and needles", Weakness of extremities, Dizziness, Lightheadedness, Gait disturbances

If Yes, Describe and/or Compare

Hematologic/Lymphatic: Easy bruising, "Red dots", Enlarged lymph nodes

If Yes, Describe and/or Compare

Endocrine: Excessive urination, Excessive thirst, Cold or heat intolerance

If Yes, Describe and/or Compare

Psychiatric: Worry, Anxiety, Panic attacks, Depression

If Yes, Describe and/or Compare

Since the last visit, did you have any changes in your medications?

If Yes, please list changes below

Since the last visit, did you develop any new allergies?

If Yes, please list changes below