

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_ DOB: \_\_\_\_\_



**RECENT OR CURRENT SYMPTOMS QUESTIONS**

Indicate below whether you have had any of these problems recently or since last seen by CCS.

GEN	Decreased exercise tolerance	Y/N	GI	Frequent Nausea	Y/N
	Fatigue	Y/N		Abdominal Pain	Y/N
	Weight Loss	Y/N		Blood in Stool	Y/N
	Weight Gain	Y/N		Constipation	Y/N
	Decrease in Appetite	Y/N		Diarrhea	Y/N
	Documented Fever	Y/N		GU	Urination More than 2X at Night
SKIN	Rash	Y/N	Blood in Urine		Y/N
	Hives	Y/N	Impotence (Men Only)		Y/N
	Hair Loss	Y/N	MS	Chronic Back Pain	Y/N
EYES	Blurred Vision	Y/N		Joint Pains	Y/N
	ENT	Hearing Loss		Y/N	Muscle Weakness
		Nose Bleed	Y/N	Unexplained Muscular Pains	Y/N
Hoarseness		Y/N	NEURO	Dizziness (Lightheadedness)	Y/N
RESP	Difficulty Breathing	Y/N		Frequent Headaches	Y/N
	Loud or Excessive Snoring	Y/N		Paralysis	Y/N
	Persistent Cough	Y/N		Speech Deficit	Y/N
	Wheezing	Y/N		Seizures	Y/N
CV	Coughing up Blood	Y/N	PSYCH	Depression	Y/N
	Heart Palpitations	Y/N		Anxiety	Y/N
	Excessive Difficulty Breathing w/Exertion	Y/N		Change in Personality	Y/N
	Chest Pain	Y/N	ENDO	Intolerance of Heat	Y/N
	Difficulty Breathing when Lying Down	Y/N		Intolerance of Cold	Y/N
	Waking up at Night Shortness of Breath	Y/N		Excessive Thirst	Y/N
	Swelling of the Feet or Legs	Y/N	HEME	Prolonged Bleeding	Y/N
	Fainting or Almost Fainting	Y/N		Excessive Bruising	Y/N
Pain in Leg Muscles with Walking	Y/N				

Please describe any other important symptoms or details here:

Please describe any Hospitalization or ER visit since you were last here:

Please list any prescriptions that need to be filled today:

Check One:  30 day supply  90 day supply

**PLEASE SEND REPORT'S FROM TODAY'S VISIT TO THE FOLLOWING DOCTORS:**

PATIENT SIGNATURE \_\_\_\_\_