CARTI Review of Symptoms

Patient Name_____ Chart _____ DOB_____

Have you recently had any of the following screenings? If so, when?

Mammogram_____ PAP Smear/Pelvic Exam_____ Colonoscopy_____

Have you had any recent immunizations, if so what type and when: _____

How long have you had this problem? _____

Please check the box of any symptoms you are currently experiencing:

GENERAL:
- ❍ Fever / chills
- ❍ Loss of appetite
- ❍ Weight loss / weight gain
- ❍ Fatigue / low energy
- ❍ Night sweats / hot flashes
- ❍ Pain

EYES:
- ❍ Redness
- ❍ Double vision
- ❍ Increased tearing
- ❍ Light sensitivity
- ❍ Impaired vision

EARS, NOSE, THROAT:
- ❍ Balance issues
- ❍ Earache
- ❍ Loss of hearing
- ❍ Ringing in ears
- ❍ Nose bleed
- ❍ Congestion
- ❍ Hoarseness
- ❍ Sore throat
- ❍ Unable to swallow
- ❍ Gums bleeding
- ❍ Sore in mouth
- ❍ Diminished taste
- ❍ Dry mouth

HEART:
- ❍ Chest pain
- ❍ Trouble breathing while lying down
- ❍ Heart racing
- ❍ Swelling
- ❍ Fainting

BREATHING:
- ❍ Shortness of breath
- ❍ Cough
- ❍ Cough with sputum
- ❍ Cough with blood
- ❍ Wheezing
- ❍ Pain with breathing

BREAST:
- ❍ Breast mass
- ❍ Breast pain
- ❍ Nipple discharge

GI/STOMACH:
- ❍ Abdominal cramping / pain
- ❍ Change in bowel habits
- ❍ Constipation
- ❍ Diarrhea
- ❍ Heartburn
- ❍ Jaundice
- ❍ Dark / black stools
- ❍ Nausea
- ❍ Vomiting

GENITOURINARY:
- ❍ Burning with urination
- ❍ Blood in urine
- ❍ Increased urination

MUSCULOSKELETAL:
- ❍ Joint pain
- ❍ Back pain
- ❍ Bone pain
- ❍ Joint stiffness
- ❍ Muscles pain / weakness

SKIN:
- ❍ Rash
- ❍ Dry skin
- ❍ Nodules / blisters
- ❍ Nail changes

NEUROLOGIC:
- ❍ Abnormal gait
- ❍ Tingling / numbness
- ❍ Confusion
- ❍ Dizziness
- ❍ Headache
- ❍ Memory loss
- ❍ Seizures

PSYCHIATRIC:
- ❍ Anxiety / depression
- ❍ Insomnia
- ❍ Poor concentration
- ❍ Mood swings

ENDOCRINE:
- ❍ Cold intolerance
- ❍ Heat intolerance
- ❍ Increased sweating
- ❍ Increased thirst

HEMATOLOGY:
- ❍ Easy bruising
- ❍ Prolonged bleeding
- ❍ Swollen glands
- ❍ Lymphedema

ALLERGY/IMMUNOLOGY:
- ❍ Eczema
- ❍ Frequent infections
- ❍ Respiratory infections
- ❍ Seasonal allergies

To be filled out by medical team:

Height_____ Weight_____ Temp._____ Pulse_____ Resp._____ Blood Pressure_____

_____ PATIENT SIGNATURE

_____ MD/RN/SCRIBE SIGNATURE