Charleston Pulmonary Associates, P.A.

Name:_____ **Date:**_____

If you have experienced any of the following in past 4 weeks, please mark appropriate **YES or NO** answer

General/Constitutional	**Yes**	**No**
Change in appetite	○	○
Chills	○	○
Fatigue	○	○
Fever	○	○
Weight loss	○	○
Allergy/Immunology	**Yes**	**No**
Hives	○	○
Rash	○	○
Watery eyes	○	○
Sneezing	○	○
Ophthalmologic	**Yes**	**No**
Blurred vision	○	○
Diminished visual acuity	○	○
Dry eye	○	○
Discharge	○	○
ENT	**Yes**	**No**
Difficulty swallowing	○	○
Dry mouth	○	○
Sore throat	○	○
Swollen glands	○	○
Nosebleed	○	○
Nasal congestion	○	○
Endocrine	**Yes**	**No**
Diabetes	○	○
Thyroid disease	○	○
Heat intolerance	○	○
Cold intolerance	○	○
Respiratory	**Yes**	**No**
Cough	○	○
Pain with inspiration	○	○
Wheezing	○	○
Cough with Blood	○	○
Shortness of breath	○	○
Sputum production	○	○
Cardiovascular	**Yes**	**No**
Chest pain with exertion	○	○
Difficulty laying flat	○	○
Fluid accumulation in the legs	○	○
Irregular heartbeat	○	○
Weight gain	○	○
Palpitations	○	○
Gastrointestinal	**Yes**	**No**
Abdominal pain	○	○
Constipation	○	○
Diarrhea	○	○
Vomiting	○	○
Nausea	○	○
Heartburn	○	○
Difficulty swallowing	○	○
Hematology	**Yes**	**No**
Recent transfusion	○	○
Easy bruising	○	○
Prolonged bleeding	○	○
Musculoskeletal	**Yes**	**No**
Painful joints	○	○
Swollen joints	○	○
Joint stiffness	○	○
Muscle aches	○	○
Skin	**Yes**	**No**
Sun sensitivity	○	○
Skin lesion(s)	○	○
Rash	○	○
Neurologic	**Yes**	**No**
Tingling/Numbness	○	○
Loss of use of extremity	○	○
Dizziness	○	○
Stroke	○	○
Psychiatric	**Yes**	**No**
Anxiety	○	○
Depressed mood	○	○
Difficulty sleeping	○	○
Stressors	○	○