Patient Name:_____Date:_____

CORNERSTONE HEALTH AND FAMILY PRACTICE
REVIEW OF SYMPTOMS

CIRCLE ALL THAT APPLY TO YOUR HEALTH

GENERAL	**RESPIRATORY**	**CARDIAC**	**GASTRO**
Weight change Fever Heat / cold intolerance Change of vision Change in hearing Change of voice Alcohol Use Tobacco Use Street drug use	Wheezing Cough Shortness of breath	Chest Pain Irregular heart beat Swelling of feet	Abdominal pain Nausea Vomitting Diarrhea Constipation Heartburn Bloody stools
URINARY	**SKIN**	**NEURO/PSYCH**	**MUSCULAR**
Blood in urine Urinary burning Frequent urinating Loss of control	Skin rash Bruise easy Change in moles	Change of sleep Headaches Numbness Tremors Seizures Dizziness Depression Anxiety Suicidal thoughts	Joints hurt Muscles hurt
FEMALES	**MALES**		
Breast lumps Nipple discharge Vaginal discharge Change in period	Impotence Erection problems		