Name: _____ Age: _____ Date: _____

Check if present in the last 30 days:

Symptoms	
Fevers	☐
Sweats	☐
Chills	☐
Flushing	☐
Rash	☐
Fatigue, tiredness, poor stamina	☐
Unexplained hair loss	☐
Swollen glands	☐
Sore throat	☐
Testicular pain	☐
Pelvic pain	☐
Unexplained menstrual irregularity	☐
Breast pain	☐
Bladder irritability/ dysfunction	☐
Sexual dysfunction/ Loss of libido	☐
Nausea	☐
Abdominal pain	☐
Constipation	☐
Diarrhea	☐
Chest pain	☐
Rib soreness	☐
Shortness of breath	☐
Cough	☐
Heart palpitations, pulse skips	☐
Neck stiffness/ Back stiffness	☐
Neck cracks	☐
Neck pain	☐
Joint stiffness	☐
Joint swelling	☐
Joint pain	☐
Muscle pain	☐
Muscle cramps	☐
Twitching of muscles	☐
Headache	☐
Numbness/ Tingling	☐
Facial paralysis	☐
Blurry vision	☐
Floaters	☐
Light sensitivity	☐
Ear buzzing/ ringing	☐
Ear pain	☐
Sound sensitivity	☐
Poor balance	☐
Lightheadedness, wooziness	☐
Tremor	☐
Confusion	☐
Difficulty thinking	☐
Forgetfulness	☐
Poor short term memory	☐
Disorientation, getting lost	☐
Difficulty with speech	☐
Word-finding problems	☐
Reversing numbers or letters	☐
Difficulty writing	☐
Mood swings	☐
Depression/ anxiety	☐
Disturbed sleep	☐
Other: _____	☐