

Gaston Women's Healthcare

Please circle Y or N if you have any of these symptoms on a regular basis.

Constitutional Symptoms

Fever Y N
 Chills Y N
 Headache Y N
 Other _____ Y N

Integumentary

Skin rash Y N
 Boils Y N
 Persistent rash Y N
 Other _____ Y N

Eyes

Blurred Vision Y N
 Double Vision Y N
 Pain Y N
 Other _____ Y N

Allergic/Immunologic

Hay Fever Y N
 Drug allergies Y N
 Other _____ Y N

Ear/Nose/Throat/Mouth

Ear Infection Y N
 Sore Throat Y N
 Sinus Problems Y N
 Other _____ Y N

Musculoskeletal

Joint Pain Y N
 Neck Pain Y N
 Back Pain Y N
 Other _____ Y N

Neurological

Tremors Y N
 Dizzy Spells Y N
 Numbness Y N
 Tingling Y N
 Other _____ Y N

Genitourinary

Blood in urine Y N
 Urine retention Y N
 Painful urination Y N
 Frequent urination Y N
 Urinary loss Y N
 Other _____ Y N

Cardiovascular System

Chest Pain Y N
 Varicose Veins Y N
 High Blood Pressure Y N
 Other _____ Y N

Endocrine

Excessive thirst Y N
 Too hot/too cold Y N
 Too tired Y N
 Sluggish Y N
 Other _____ Y N

Respiratory

Wheezing Y N
 Frequent cough Y N
 Shortness of breath Y N
 Other _____ Y N

Gastrointestinal

Abdominal Pain Y N
 Nausea Y N
 Vomiting Y N
 Indigestion Y N
 Heartburn Y N
 Other _____ Y N

Psychological

Are you satisfied with your life? Y N
 Do you feel depressed? Y N
 Have you ever considered suicide? Y N

Providers use only:

# Answers:	0-1	2-9	10+
Comments/Notes: _____			
Level of service: 1 2 3 4 5			
Provider Signature: _____			

Patient signature: _____ Date: _____