

Problem Checklist

Patient: _____ Last Name _____ First Name _____ Middle Initial _____ Date of Birth: MM / DD / YYYY

Home Address: _____ Street _____ City _____ State _____ Zip Code _____

Marital Status: S M W D Sep

Do you have a living will? Y N

PROBLEM CHECKLIST

If you have recently or recurrently noted the any of the following problems, please check (✓) the box by the condition listed.

General	<input type="checkbox"/> Fever <input type="checkbox"/> Sweats <input type="checkbox"/> Unintended weight change (how much over what period? _____)	<input type="checkbox"/> Chills <input type="checkbox"/> Malaise or "feeling ill" <input type="checkbox"/> Fatigue
Head	<input type="checkbox"/> Headache	<input type="checkbox"/> Head injury
Ears	<input type="checkbox"/> Ringing <input type="checkbox"/> Ear pain <input type="checkbox"/> Ear discharge	<input type="checkbox"/> Change in hearing <input type="checkbox"/> Blockage <input type="checkbox"/> Dizziness
Nose	<input type="checkbox"/> Congestion <input type="checkbox"/> Persistently discolored discharge <input type="checkbox"/> Sinus pressure	<input type="checkbox"/> Clear discharge <input type="checkbox"/> Post nasal drip <input type="checkbox"/> Sinus pain
Throat	<input type="checkbox"/> Sore throat <input type="checkbox"/> Laryngitis <input type="checkbox"/> Itchy throat	<input type="checkbox"/> Dental problem <input type="checkbox"/> Persistent hoarseness <input type="checkbox"/> Snoring
Eyes	<input type="checkbox"/> Change in vision <input type="checkbox"/> Flashing or scintillating lights <input type="checkbox"/> Partial loss of vision (central, peripheral, or field) <input type="checkbox"/> Eye pain	<input type="checkbox"/> Sudden loss of vision <input type="checkbox"/> Dark spots or "floaters" <input type="checkbox"/> Eye discharge <input type="checkbox"/> Itchy or irritable
Heart	<input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Swelling of feet or ankles	<input type="checkbox"/> Palpitations <input type="checkbox"/> Racing heart
Lungs	<input type="checkbox"/> Trouble breathing (intermittent or constant) <input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing <input type="checkbox"/> Painful breathing
Digestive	<input type="checkbox"/> Heartburn or acid reflux <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in stool <input type="checkbox"/> Excessive bloating or gas	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Black tarry stool
Bones and Joints	<input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain (stiffness or restricted mobility)	<input type="checkbox"/> Neck pain <input type="checkbox"/> Muscle aches
Neurological	<input type="checkbox"/> Weakness <input type="checkbox"/> Abnormal sensations <input type="checkbox"/> Seizures	<input type="checkbox"/> Numbness <input type="checkbox"/> Fainting <input type="checkbox"/> Restless legs
Psychological	<input type="checkbox"/> Anxious <input type="checkbox"/> Feeling hopeless, helpless, or worthless <input type="checkbox"/> Unable to enjoy life <input type="checkbox"/> Uncontrollable anger or irritability <input type="checkbox"/> Wanting to hide, disappear, or die	<input type="checkbox"/> Panic attack <input type="checkbox"/> Persistent sadness <input type="checkbox"/> Insomnia <input type="checkbox"/> Poor appetite or stress eating <input type="checkbox"/> Wanting to hurt someone
Skin	<input type="checkbox"/> Abnormal or changing mole <input type="checkbox"/> Lesions of concern <input type="checkbox"/> Swollen glands <input type="checkbox"/> Change in texture	<input type="checkbox"/> Rashes <input type="checkbox"/> Dryness <input type="checkbox"/> Bruising <input type="checkbox"/> Hair or nail changes