Please complete the following:

Name: __________________________

Last    First    MI

Over the past several weeks, have you experienced any of the following symptoms:

**General**
- □ Fatigue
- □ Fever

**Ear/Nose/Throat**
- □ Dry mouth
- □ Runny nose
- □ Vision changes
- □ Speech changes
- □ Dizziness / vertigo

**Gastrointestinal**
- □ Difficulty swallowing
- □ Reflux / heartburn
- □ Constipation
- □ Diarrhea

**Musculoskeletal**
- □ Muscle pain
- □ Joint pain
- □ Swelling
- □ Falls
- □ Imbalance / difficulty walking

**Dermatologic**
- □ Rash

**Neurologic**
- □ Headaches
- □ Memory Loss
- □ Difficulty with concentration
- □ Seizure
- □ Numbness / tingling
- □ Weakness
- □ Muscle twitching / cramping

**Respiratory**
- □ Shortness of breath
- □ Cough

**Endocrine**
- □ Weight loss
- □ Weight gain

**Hematologic**
- □ Easy bruising

**Psychological**
- □ Depression
- □ Anxiety
- □ Anger / irritability
- □ Hallucinations / delusions
- □ Suicidal thoughts

**Cardiovascular**
- □ Chest pain
- □ Palpitations
- □ Lower extremity swelling

**Genitourinary**
- □ Need to urinate at night
- □ Frequent urination
- □ Urinary incontinence

- □ Other:
  __________________________
  __________________________
  __________________________