RCSM
RESPIRATORY CARE
+ SLEEP MEDICINE

Name _____ **DOB** _____

(Please print clearly)

CURRENT SYMPTOMS (Please circle all that apply)

General

Chills

Daytime Sleepiness

Fatigue

Fever

Frequent Illnesses

Weight Gain

Weight Loss

Skin

Hair Loss

Urticaria (Hives)

HEENT

Allergies

Bloody Nose

Blurred vision

Congestion

Dental Problems

Ears/Nose/Throat Pain

Eye Pain

Hearing Problems

Hoarseness

Light Sensitivity

Post Nasal Drip

Runny Nose

Snoring

Respiratory

Cough

Coughing up blood

Shortness of Breath

Wheezing

Cardiovascular

Chest Pain

Palpitations

Shortness of Breath, when lying

Swollen Ankles

Tachycardia (fast heart rate)

Gastrointestinal

Abdominal Pain

Constipation

Diarrhea

Heartburn

Stool Changes

Male Genitourinary

Dysuria (painful urination)

Genital Lesions

Urinating blood

Musculoskeletal

Arthralgias (joint pain)

Back Pain

Myalgias (muscle pain)

Neurological

Bed Wetting

Dizziness

Falling asleep during the day

Headaches

Leg Aching

Leg Twitching

Night Terrors

Nightmare

Pins and needles

Sleep Talking

Sleep Walking

Unable to relax leg

Weakness

Psychiatric

Anxiety

Depression

Sleep Disturbances

Endocrine

Cold Intolerance

Heat Intolerance

Increased Hunger

Increased Thirst

Increased Urine

Hematology

Bleeding

Easy Bruising

HIV Exposure

Swollen lymph nodes

Primary Care Physician _____

Pharmacy name and location _____

Have you had any recent testing and/or hospital stay? _____