KAISER PERMANENTE®

Specialty Services: Patient questionnaire
Review of common symptoms

Patient Name:

Please fill out this form and give it to the specialist you will be seeing today. Your specialist will review your answers to see if there is anything that needs to be addressed today.

Please check the boxes below if you have had any of the following symptoms in the last 30 days
Check all that apply:

General

- ☐ Fever
- ☐ Night sweats
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Weakness or feeling very tired

Eyes, ears, nose, and throat

- ☐ Vision changes
- ☐ Ringing in ears
- ☐ Lump or mass in neck
- ☐ Frequent bloody nose
- ☐ Itchy nose, sneezing often
- ☐ Changes in voice

Heart and circulation

- ☐ Chest discomfort or pain
- ☐ Fast or irregular heartbeat
- ☐ Trouble breathing while lying flat
- ☐ Leg swelling
- ☐ Leg or calf pain with exercise

Breathing and respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Feeling very sleepy or dozing during the day
- ☐ Hard time sleeping
- ☐ Severe snoring

Urinary and genital

- ☐ Having to urinate often during the day
- ☐ Having to urinate often at night
- ☐ Blood in urine
- ☐ Leaking urine or having a sudden urge to urinate
- ☐ Pain or burning with urination

Bones, muscles, and joints

- ☐ Joint pain
- ☐ Back pain
- ☐ Leg cramping or restless legs
- ☐ Muscle pain or weakness

Glands and endocrine system

- ☐ Blood sugar that is very high or out of control
- ☐ Sensitive to cold
- ☐ Sensitive to heat
- ☐ More thirsty than usual

Blood and tissue

- ☐ Swollen nodes or glands
- ☐ Easy bleeding or bruising

Nervous system

- ☐ Falls
- ☐ Passing out
- ☐ Dizzy or lightheaded
- ☐ Headaches
- ☐ Feel like things are spinning
- ☐ Seizures
- ☐ Numbness or tingling of hands or feet
- ☐ Tremors
- ☐ Changes in memory

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Stomach and intestines
☐ Nausea or vomiting
☐ Trouble swallowing
☐ Heartburn or acid reflux
☐ Pain in abdomen or rectum
☐ Bloody, dark, or black stool
☐ Constipation
☐ Diarrhea
☐ Change in bowel habits

Psychiatric
☐ Anxiety
☐ Depression

Skin
☐ New rash
☐ Itching
☐ New skin lump
☐ Any changes in a wart or mole

Are you having any other symptoms not listed above? ☐ No ☐ Yes

If yes, please list:

_____

_____

Safety

Have you ever been a victim of threats, physical hurting, or forced sexual contact?

☐ Yes ☐ No

Habits and lifestyle

Do you exercise regularly? ☐ Yes ☐ No

If yes, what do you do and how often? _____

Average number of hours you sleep each night: _____

How many caffeinated drinks do you have each day? _____

Do you eat or drink dairy? ☐ Yes ☐ No

If yes, what kinds of dairy and how many servings do you have each day?

_____

_____

_____

For women:

Are you pregnant: ☐ Yes ☐ No

Is there anything else you would like your provider to know?

_____

_____

_____

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