Academic Dermatology of Nevada
The smart approach to skin disorders.

Curt Samlaska, MD, FACP, FAAD
Kristine Herlevi, PA-C
2839 St. Rose Parkway, Suite 100
Henderson, NV 89052
(702) 837-8988, Fax (702) 990-5269

Review Of Symptoms

Patient Name: _____ **Date:** _____

Name of Primary Care Provider (PCP): _____ **Send letter to PCP?** **No** **Yes**

PLEASE INDICATE BELOW. ARE YOU *CURRENTLY* EXPERIENCING ANY OF THESE SYMPTOMS:

General, constitutional **None:** ☐

Poor health lately	no	yes
Recent weight change	no	yes
Fever	no	yes
Fatigue	no	yes

Eyes and vision **None:** ☐

Eye disease or injury	no	yes
Wear glasses or contact lenses	no	yes
Blurred or double vision	no	yes
Glaucoma	no	yes

Ears, nose, throat **None:** ☐

Hearing loss	no	yes
Ringing in the ears	no	yes
Earaches or drainage	no	yes
Sinus problems	no	yes
Nose bleeds	no	yes
Mouth sores	no	yes
Bleeding gums	no	yes
Bad breath or bad taste	no	yes
Sore throat or voice change	no	yes
Swollen glands in neck	no	yes

Heart and Cardiovascular **None:** ☐

Heart trouble or murmur	no	yes
Chest pains	no	yes
Sudden heartbeat changes	no	yes
Swelling of feet, ankles, hands	no	yes

Respiratory **None:** ☐

Frequent coughing	no	yes
Spitting up blood	no	yes
Shortness of breath	no	yes
Asthma or wheezing	no	yes

Gastrointestinal **None:** ☐

Loss of appetite	no	yes
Change in bowel movements	no	yes
Nausea or vomiting	no	yes
Frequent diarrhea	no	yes
Painful bowel movements or constipation	no	yes
Blood in stool	no	yes
Stomach pain	no	yes

Genitourinary **None:** ☐

Frequent urination	no	yes
Burning or painful urination	no	yes
Blood in urine	no	yes
Change in force or strain with urination	no	yes
Incontinence or dribbling	no	yes
Kidney stones	no	yes
Sexual difficulty	no	yes
Painful periods	no	yes
Irregular periods	no	yes
Vaginal discharge	no	yes

Musculoskeletal **None:** ☐

Joint pain	no	yes
Joint stiffness or swelling	no	yes
Weakness of muscles/joints	no	yes
Muscle pain or cramps	no	yes
Back pain	no	yes
Cold extremities	no	yes
Difficulty in walking	no	yes

Skin and breasts **None:** ☐

Rash or itching	no	yes
Change in moles	no	yes
Change in hair or nails	no	yes
Change in skin color	no	yes
Breast pain	no	yes
Breast lump	no	yes
Breast discharge	no	yes

Neurologic **None:** ☐

Frequent or recurrent headaches	no	yes
Light headed or dizzy	no	yes
Convulsions or seizures	no	yes
Numbness or tingling sensations	no	yes
Tremors	no	yes
Paralysis	no	yes
Stroke	no	yes
Head injury	no	yes

Psychiatric **None:** ☐

Memory loss or confusion	no	yes
Nervousness	no	yes
Depression	no	yes
Sleep problems	no	yes

Endocrine

Glandular or hormone problem	no	yes
Thyroid disease	no	yes
Diabetes	no	yes
Excessive thirst or urination	no	yes
Heat or cold intolerance	no	yes
Dry skin	no	yes
Change in hat or glove size	no	yes

Hematologic/Lymphatic **None:** ☐

Slow to heal after cuts	no	yes
Easily bruise or bleed	no	yes
Anemia	no	yes
Phlebitis	no	yes
Transfusion	no	yes
Swollen glands	no	yes

Patient sign here: _____

Date: _____