Academic Dermatology of Nevada
The smart approach to skin disorders.

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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:** ☐	
Chills	no	yes
Fatigue	no	yes
Fever	no	yes
Night sweats	no	yes
Weight loss	no	yes

Eyes and vision	**None:** ☐	
Difficulties/Vision	no	yes
Blurry or double vision	no	yes
Eye disease	no	yes
Glaucoma	no	yes

Ears, nose, throat	**None:** ☐	
Nasal or mouth sores	no	yes
Nasal or mouth dryness	no	yes
Nose bleeds	no	yes
Hearing loss	no	yes
Ringing in ears	no	yes
Loss of smell	no	yes
Mouth and or gum disease	no	yes
Sore Throat	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:** ☐	
Coughing or shortness of breath	no	yes
Sputum production	no	yes
Wheezing	no	yes
Coughing up blood	no	yes

Gastrointestinal	**None:** ☐	
Nausea or vomiting	no	yes
Black or tarry stools	no	yes
Blood in stools	no	yes
Abdominal pain	no	yes
Change in bowel movements	no	yes
Constipation	no	yes
Diarrhea	no	yes

Endocrine	**None:** ☐	
Hormonal problems	no	yes
Heat or cold intolerance	no	yes
Dry skin	no	yes
Swollen glands	no	yes
Excessive thirst	no	yes
Excessive urination	no	yes
Thyroid disease	no	yes

Musculoskeletal	**None:** ☐	
Muscle pain or cramps	no	yes
Back pain	no	yes
Cold extremities	no	yes
Joint aches	no	yes
Difficulty walking	no	yes
Decreased joint range of motion	no	yes
Muscle pain or cramps	no	yes

Additional Skin History	**None:** ☐	
Acne	no	yes
Dry lips	no	yes
Hair and nail changes	no	yes
Change in skin color	no	yes
Rash or itching	no	yes
Varicosities	no	yes
Breast lump, pain or 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:** ☐	
Think of suicide	no	yes
Anxiety	no	yes
Depression	no	yes
Memory loss	no	yes

Hematology	**None:** ☐	
Unusual bruising	no	yes
Blood clots	no	yes
Anemia	no	yes
Swollen glands	no	yes
Delayed healing	no	yes
Hepatitis exposure	no	yes
Bleeding problems	no	yes

Allergy history	**None:** ☐	
Hay fever history	no	yes
Asthma	no	yes
Nasal congestion	no	yes
Food allergy	no	yes
Itching	no	yes

Patient sign here: _____

Date: _____