IMPC
Internal Medicine Primary Care

Review of Symptoms for Today's Visit

Date: _____

Name: _____ DOB: _____

GENERAL
- ☐ Fatigue "feel tired"
- ☐ Fever or chills
- ☐ Weight loss/gain
- ☐ Sleeping changes
- ☐ Body aches
- ☐ Frequent Illnesses

EYES
- ☐ Pain
- ☐ Vision loss/change
- ☐ Redness

HEAD
- ☐ Headache
- ☐ Head injury

EARS
- ☐ Decreased hearing
- ☐ Ear fullness
- ☐ Earache
- ☐ Ear drainage

NOSE
- ☐ Stuffy/runny
- ☐ Sinus pain
- ☐ Nosebleeds

THROAT
- ☐ Hoarseness
- ☐ Trouble swallowing
- ☐ Sore throat

NECK
- ☐ Swollen glands
- ☐ Pain
- ☐ Stiffness

BREASTS
- ☐ Lumps
- ☐ Tenderness
- ☐ Discharge
- ☐ Redness

CARDIOVASCULAR
- ☐ Chest pain/discomfort
- ☐ Irregular heart beats
- ☐ Swelling of legs
- ☐ Tightness

RESPIRATORY
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Cough
- ☐ Sputum/phlegm

GASTROINTESTINAL
- ☐ Nausea/vomiting
- ☐ Pain in abdomen
- ☐ Diarrhea
- ☐ Constipation
- ☐ Yellow skin/eyes
- ☐ Heartburn
- ☐ Change in appetite
- ☐ Rectal bleeding/melena

Urinary
- ☐ Frequency/urgency
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Decreased stream
- ☐ Burning/pain

Skin
- ☐ Rashes
- ☐ Itching
- ☐ Hair/nail changes

Neurologic
- ☐ Weakness
- ☐ Tingling/numbness
- ☐ Seizures
- ☐ Dizziness

Musculoskeletal
- ☐ Muscle/joint pain
- ☐ Swelling of joints
- ☐ Muscle cramps
- ☐ Redness of joints
- ☐ Calf pain
- ☐ Stiffness

Endocrine
- ☐ Increased urination
- ☐ Increased thirst
- ☐ Heat/cold intolerance

Psychiatric
- ☐ Depression
- ☐ Nervousness
- ☐ Stress

Hematologic/Lymph
- ☐ Bleeding easily
- ☐ Bruising easily
- ☐ Enlarged lymph nodes

Please turn over

Reason(s) for today's visit (in a few brief sentences)

_____

_____

_____

_____

What are you allergic to?	**What is the reaction?**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medications you are currently taking	**Dose**	**How often**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements you are currently taking	**Dose**	**How often**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____