OSCAR MEDICAL CENTER
REVIEW OF SYMPTOMS FORM (GENERIC)

Name:

Date of Birth: / /

Today's Date: / /

Please review the symptoms below. If you have had any of these symptoms within the last 6 months, please check the appropriate box. If you have NOT had any of these symptoms, please check the "NONE" box.

GENERAL	☐ fever	☐ chills	☐ fatigue	☐ weight loss	☐ decreased appetite	☐	☐ **NONE**
NEURO	☐ headache	☐ seizures	☐ weakness	☐ dizziness	☐ poor balance	☐	☐ **NONE**
EYES	☐ glaucoma	☐ eye pain	☐ double vision	☐ red eyes	☐need glasses/contacts	☐	☐ **NONE**
EARS	☐ ear pain	☐ sore throat	☐ hearing loss	☐ hear beeps	☐ sinus drainage	☐	☐ **NONE**
HEART	☐ chest pain	☐ chest pressure	☐ legs swelled	☐feet swelled	☐ irregular heartbeat	☐	☐ **NONE**
LUNGS	☐ cough	☐ wheezing	☐ sleep apnea	☐ chest pain	☐ shortness of breath	☐	☐ **NONE**
SKIN	☐ rash	☐ hives	☐ itching	☐ blisters	☐ bruising	☐ bug bites	☐ **NONE**
MUSCLES	☐ fracture	☐ prior fracture	☐ muscle pain	☐ arthritis	☐ osteoporosis	☐ spasms	☐ **NONE**
ABDOMEN	☐ nausea	☐ stomach ulcer	☐ heartburn	☐ sharp pain	☐ change in stool	☐	☐ **NONE**
URINARY	☐ discharge	☐ blood in urine	☐ incontinence	☐ urgency	☐ painful/freq. urination	☐	☐ **NONE**
BLOOD	☐ blood clots	☐ bleeding issues	☐ anemia	☐ nosebleeds	☐ easy bruising	☐	☐ **NONE**
ALLERGY	☐ hives	☐ skin reactions	☐ can't breathe	☐ severe pain	☐ Anaphylaxis	☐ toxic shock	☐ **NONE**
IMMUNE	☐ allergies	☐ frequent infections	☐ leukemia	☐ tuberculosis	☐ auto immune deficiency	☐	☐ **NONE**
PSYCHIATRIC	☐ anxiety	☐ TBI recently?	☐ depression	☐ paranoia	☐ changes in sleep habits	☐ anger	☐ **NONE**
ENDOCHRINE	☐ thyroid	☐ excessive thirst	☐ diabetes	☐ sweating	☐	☐	☐ **NONE**

List any medical conditions that run in your family:

_____

_____

_____

Have you traveled to any of the following West African areas within the last 21 days?

Sierra Leone ☐ Yes ☐ No

Guinea ☐ Yes ☐ No

Liberia ☐ Yes ☐ No