ALL ISLAND GASTROENTEROLOGY & LIVER ASSOCIATES, P. C.

Patient Name	Date of Birth	Today's Date
_____	_____	_____

REVIEW OF SYMPTOMS

Do you currently have any of these symptoms? Please circle those that apply

General:	Change in general health Change in strength: stamina Fevers/Sweats
Endocrine:	Unusual change in weight Fatigue/lethargy Change in Appetite
Heart and Circulation:	Chest Pain Palpitations Swelling in Legs
Lungs:	Cough Shortness of Breath Wheezing
Neurologic:	Headache Poor Balance Tingling in fingers/toes
Muscles/ Bones:	Joint aches Muscle weakness/pain
Mood:	Anxiety/depression Poor sleep Difficulty concentrating
Allergy:	Hives Allergic reaction to medicine
Mood:	Anxiety/depression
Eyes:	Changes in vision Eye pain
Ears, Nose, Throat:	Hearing Loss Nose Bleeds Sore throat, voice changes
Skin:	Rash Discoloration Hair Loss
Genito-Urinary:	Difficulty urinating Blood in Urine Change in Sexual Function
Stomach/ Intestines:	Nausea Vomiting
Digestion:	Heartburn Abdominal Pain Difficulty swallowing Bloating/gas Blood in Stool Change in Bowel Habits Diarrhea Constipation Belching Rectal Bleeding Abdominal bowel sounds Hemorrhoids
Other:	_____ _____