# What symptoms are you having today?

**NAME:**_____ **DATE:**_____

- ☐ Fever
- ☐ Chills
- ☐ Headaches
- ☐ Blurred Vision
- ☐ Pain
- ☐ Sore Throat
- ☐ Sinus Pain
- ☐ Mouth Ulcers
- ☐ Runny Nose
- ☐ Tremor
- ☐ Dizziness
- ☐ Tingling/numbness
- ☐ Too Hot/Cold
- ☐ Tired/Sluggish
- ☐ Loss of Libido
- ☐ Rash
- ☐ Itching
- ☐ Boils
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Chest Pain
- ☐ Varicose Veins
- ☐ High Blood Pressure
- ☐ Swelling of ankles
- ☐ Joint Pain
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Urinary Incontinence
- ☐ Pain with Urination
- ☐ Urinary Urgency
- ☐ Urinary Frequency
- ☐ Urinary Retention
- ☐ Pain with Intercourse
- ☐ Erectile Dysfunction
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Seasonal Allergies
- ☐ Swollen Glands
- ☐ Blood Clotting Problem
- ☐ Anxiety
- ☐ Depression