New Symptoms Checklist

USES: (1) Consults (2) Calls (3) Fax to number provided by your doctor for non-emergencies

Name _____ Phone _____

My Diagnosis: _____ Recently treated? Yes / No

Doctor: _____ **Phone:** _____ **Fax:** _____

Circle or write answers in underlined areas

MY SYMPTOMS:

Level of concern: Urgent (Call) | High | Medium | Low

1. **Describe primary symptoms of concern:** _____
   _____
   _____
2. Do **symptoms come and go?** Yes / No
   - Random (not predictable)? Yes / No | Time of day: _____
3. Describe when symptoms started _____
4. How long symptoms have lasted _____
5. **Pain?** Yes / No
   - Type: aching, dull, sharp | bloating, numbing, shooting | burning, pressing, soreness cramping, pressure, stabbing | comes and goes, pulling, throbbing constant, radiating, tightness | cutting, searing (circle all that apply)

     Describe: _____
   - Intensity: (1 to 10 highest) _____ Location: _____
   - Does pain change when you change position? Yes / No

     Describe: _____
6. **Fever?** Yes / No Temperature: _____ Range/duration: _____

Potential Indications of an Emergency (CALL 911)

- Difficulty breathing , or you suspect an acute allergic reaction
- Chest pain, pressure, tightening
- New onset of severe pain
- Visual changes: blurred vision, loss of vision, partial loss of vision
- Numbness and tingling in arms and legs that won't go away
- Sudden onset of confusion, disorientation, memory loss,
- High fever (101 or higher) – particularly if you are immune suppressed

***Ask your doctor** for guidance on what constitutes a medical emergency and the actions you should take!*

Common Systemic / "B"-Symptoms

Circle all that apply

- Drenching night sweats
- Fatigue (scale 1 – 10) _____
- Fever and chills
- Rash – itching skin
- Unexplained weight loss

7. **New** lumps**,** fullness**,** lesions or lymph nodes**?** (circle all that apply)

   - Near existing sites? Yes / No | Away from existing sites? Yes / No

     Describe: _____

   - Change in size of existing lumps, lesions or lymph nodes: Yes / No

     Describe: _____

   - Change in appearance of visible lesions? Yes / No Painful? Yes / No

     Describe: _____

8. Are the **symptoms associated** with: (circle all that apply)

   Environment or New pets Describe: _____

   Meals Describe: _____

   Medications Describe: _____

9. Do you have **Nausea** Yes / No **Bowel** Yes / No or **Urination** Yes / No **difficulties?**

   Describe frequency _____ duration _____ intensity: _____

   _____

10. **What is your level of energy?** Very good, Normal, Low, Very low (cannot do normal activities)

11. Do you have a **rash:** Yes / No **Describe: Size** _____ **Color** _____ Raised or Smooth

    Location (one area, many distinct areas): _____

12. **Are you feeling** stressed **or** depressed**?** (circle) **Intensity:** (1 to 10 highest) _____

13. **Other:** _____

MY MEDICATIONS including recently discontinued (mark with D)

Circle new medications

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The intended purpose of this form is to help patients to communicate with their doctors about new symptoms of concern.

The form should not be considered a comprehensive list of medical symptoms or a substitute for medical guidance from a trained physician.

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