New Symptoms Checklist

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
   o Random (not predictable)? Yes / No | Time of day: ____________________________

3. Describe when symptoms started ____________________________

4. How long symptoms have lasted ____________________________

5. Pain? Yes / No
   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)

   o Type:
   Describe: ____________________________

   o Intensity: (1 to 10 highest) _____ Location: ____________________________

   o 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)
   o Near existing sites? Yes / No | Away from existing sites? Yes / No
   Describe: ____________________________

   o Change in size of existing lumps, lesions or lymph nodes: Yes / No
   Describe: ____________________________

   o 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: ____________________________