PATIENT REVIEW OF SYMPTOMS

Patient Name: _____

***Your pain level today:** /10 (with medications) /10 (without medications)
*This information is **mandatory** to continue to treat your pain. Please see the Mankoski Pain Scale.

Please circle any symptoms that you are currently experiencing.

General:	Fatigue	Fever	Insomnia	Night sweats		
	Weight loss	Weight gain				
Eyes:	Eye pain	Vision changes	Visual disturbance			
Ears/Nose/Throat:	Dizziness	Hearing Loss	Ringing in the ears			
Heart:	Arrhythmias	Chest pain	Palpitations	Swelling		
Lungs:	Cough	Difficulty breathing				
Stomach:	Abdominal pain	Constipation	Diarrhea	Nausea	Reflux	Vomiting
Urinary:	Impotence	Incontinence				
Musculoskeletal:	Pain	Sciatica	Spasms	Stiffness	Swelling	Weakness
Nerves:	**A**ltered level of consciousness		Dizziness	Headaches	Numbness	Tingling
Psychiatric:	Alcohol abuse	Anxiety	Depression	Drug abuse	Suicidal thoughts	
Skin:	Rash					
Other:	High blood sugars	Low blood sugars		Low thyroid	Overactive Thyroid	

Please circle any of the medications below if you are currently taking them.

ANTI-ANXIETY/MUSCLE RELAXANTS:

Alprazolam (Xanax)
Chlordiazepoxide (Librium)
Clonazepam (Klonopin)
Diazepam (Valium)
Flurazepam (Dalmane)
Lorazepam (Ativan)
Temazepam (Restoril)

BLOOD THINNERS:

Apixaban (Eliquis)
Clopidogrel (Plavix)
Dabigatran Etexilate (Pradaxa)
Rivaroxaban (Xarelto)
Warfarin (Coumadin)
Aspirin 81 mg 325 mg
NSAIDs: Ibuprofen (Motrin), Naprosyn (Aleve), Diclofenac (Voltaren), Etodolac (Lodine), Meloxicam (Mobic), etc.