Patient Name_____ Date of Birth_____

Whole Body Health Check

- Fill this form out to help talk about how you feel during your doctor visit.
    - **Check any symptom that you have had in the last month.**

General
- ☐ Change in life routine
- ☐ Bad sleep or feeling tired
- ☐ New pains
- ☐ Lost or gained weight, not growing
- ☐ Feel hot or cold

Head
- ☐ Runny or itchy nose or eyes
- ☐ Nosebleeds
- ☐ Snore
- ☐ Ear pain, red or draining
- ☐ Eye pain or red
- ☐ Change in hearing or vision
- ☐ Teeth pain, swollen gums or bleeding
- ☐ Swollen glands in neck

Chest
- ☐ Chest pain – grab or rub chest
- ☐ Short of breath
- ☐ Cough or wheezing
- ☐ Tire out during activity
- ☐ Fall or sit during activity
- ☐ Get very sweaty, blotchy or clammy
- ☐ Heart pound
- ☐ High blood pressure
- ☐ Pass out, faint or feel dizzy
- ☐ Swell in feet or legs

Belly
- ☐ Belly pain – hold or rub belly
- ☐ Eat only a few types of food
- ☐ Eat too little, too much or too fast
- ☐ Drink too little or too much
- ☐ Choke or noisy swallowing
- ☐ Gassy
- ☐ Sick stomach or vomit
- ☐ Swollen belly
- ☐ Watery poop or accidents
- ☐ Hard or large poop
- ☐ Blood in poop or pain when pooping
- ☐ Pee too much or accidents
- ☐ Can't pee or too little pee
- ☐ Blood in urine or burning
- ☐ Girls – problem with period

Skin, Muscles and Joints
- ☐ Rashes or itching
- ☐ Dry skin, thick callus or peeling
- ☐ Red or purple spots from pressure
- ☐ Bruises or skin color changes
- ☐ Nail or hair problems
- ☐ New lumps or bumps
- ☐ Tight muscles or stiff joints
- ☐ Joint swell, red or painful
- ☐ Change when walk or move

Brain
- ☐ Headaches – hold, rub, or bang head
- ☐ Seizure or change in seizures
- ☐ Numb, tingling or weak in body
- ☐ Moving slower or more wobbly
- ☐ Feel mixed up or confused

Mood
- ☐ Low interest in usual activities
- ☐ Not paying attention
- ☐ Hyper or racing thoughts
- ☐ Irritable or fussy or more outbursts
- ☐ Moody or sad
- ☐ Fearful or anxious
- ☐ Angry