DATE: _____/_____/_____

ANTHONY S. BORCICH, M. D., P. C.
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PATIENT SYMPTOM SURVEY

PATIENT NAME: _____

ARE THERE ANY CHANGES IN MEDICATION SINCE LAST VISIT? YES NO

IF YES, PLEASE LIST CHANGES:

_____
_____
_____
_____

ARE YOU CURRENTLY HAVING (OR RECENTLY HAD) ANY OF THE FOLLOWING? (CIRCLE ALL THAT APPLY)
HEADACHES? SINUS PROBLEMS? SNORING? NOSE BLEEDS?
COUGH, SHORTNESS OF BREATH, WHEEZING/ASTHMA?
CHEST PAIN WHILE SITTING, OR WITH EXERTION SUCH AS WALKING UP HILL OR UP STEPS; HEART PALPITATIONS, RACING HEART BEAT OR IRREGULAR HEART BEAT?
HEARTBURN, DIFFICULTY SWALLOWING, SOUR TASTE, CHANGE OF APPETITE, WEIGHT LOSS OR GAIN, STOMACH PAIN, CHANGE IN BOWEL HABITS, ANY VISIBLE BLOOD IN STOOL OR ON BATHROOM TISSUE OR BLACK STOOL?
DIFFICULTY WITH URINATION, INCREASED OR DECREASED FREQUENCY OR BURNING?
CHANGE IN STRENGTH, BALANCE, COORDINATION, ABILITY TO WALK, MEMORY OR VISION PROBLEMS?