NAME: **DATE:**

Progress Note: Mark how you *currently* feel compared to your last appointment.

SYMPTOMS	Never had	Much worse	A little worse	No change	A little better	Much Better	Resolved
Fevers							
Sweats							
Chills							
Flushing							
Fatigue, tiredness, poor stamina							
Unexplained hair loss							
Swollen glands							
Sore throat							
Testicular pain							
Pelvic pain							
Unexp. Menstrual irregularity							
Breast pain							
Bladder irritability/dysfunction							
Sexual dysfunct./Loss of libido							
Nausea							
Constipation							
Diarrhea							
Chest pain							
Rib soreness							
Shortness of breath							
Cough							
Heart palpitations/pulse skips							
Neck or back stiffness							
Neck cracks							
Neck pain							
Joint stiffness							
Joint swelling							
Joint pain							
Muscle pain							
Muscle cramps							
Twitching of muscles							
Headache							
Numbness/Tingling							
Facial paralysis							
Blurry vision							
Floaters							
Light sensitivity							
Ear buzzing/ringing							
Ear pain							
Sound sensitivity							
Poor balance							
Lightheadedness, wooziness							
Tremor							
Confusion							
Difficulty in thinking							
Forgetfulness							
Poor short term memory							
Disorientation/Getting lost/Going to wrong places							
Difficulty with speech							
Word finding problems							
Reversing numbers/letters							
Difficulty with writing							
Mood swings							
Depression/Anxiety							
Disturbed sleep (too much/little)							

Current Antibiotics:

Current Herbs:

Current Supplements:

*****Office Use*****

MY PATH MEDICAL