Patient Symptom Checklist

Patient Name: _____ Date of Birth: _____

AUTONOMIC NERVOUS SYSTEM DYSFUNCTION (ANSD)	6 Months	Today
Blurred Vision		
Elevated Blood Sugar		
Extreme Thirst		
Frequent Urination		
Fatigue (Tiredness)		
Heartburn		
Increased Hunger		
Nausea		
Numbness & Tingling in Hands or Feet		
Vomiting		
Burning Sensations		
Difficulty Digesting Food		
Dizziness or Fainting		
Exercise Intolerance		
Sexual Difficulties		
Sweat Abnormalities		
Tingling Hands & Feet		
Urinary Problems		
CARDIOMETABOLIC RISK (CMR)	6 Months	Today
Headaches		
Dizziness		
Swelling of Ankles		
SMALL FIBER SENSORY NEUROPATHY (SFN)	6 Months	Today
Burning Sensations		

ENDOTHELIAL DYSFUNCTION (ENDOD)	6 Months	Today
Angina (severe chest pain, often spreading to shoulder, arm, back, neck, or jaw)		
Chest Pain that goes away with rest		
Heartburn		
Pain In Calves		
Shortness of Breath		
Stroke		
TIA (mini stroke)		
INSULIN RESISTANCE (IR)	6 Months	Today
Blurred Vision		
Elevated Blood Sugar		
Extreme Thirst		
Fatigue (Tiredness)		
Increased Hunger		
CARDIOMETABOLIC AUTONOMIC NEUROPATHY (CAN)	6 Months	Today
Blurred Vision		
Cold, Clammy, Pale Skin		
Depression		
Dizziness or Lightheadedness		
Thirst		
Fainting		
Fatigue (Tiredness)		
Lack of Concentration		
Lack of Energy		
Nausea		

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Patient Name: _____ Date of Birth: _____

Painful Contact With Socks or Bed Sheets				Rapid, Shallow Breathing		
Pebble or Sand like Sensation In Shoes						
Stabbing or Electrical Shock Sensation						
Pins And Needles Sensation In Feet						
PLETHYSMOGRAPHY CARDIOVASCULAR DISEASE (PTG CVD)	6 Months	Today				
Blood clot in a vein (Venous Thrombosis)						
Heart Attack						
Irregular heartbeat, too fast/slow (Atrial Fibrillation)						
Stroke						

I authorize the release of my test results, with all identifiable information removed, to Health Profit Solutions, Inc. and PECE, LLC to be used in aggregating data which allows for improving the effectiveness of testing and treatment. The test results will not have any impact on my care, treatment or my cost of care or treatment.

Patient Signature: _____ Date Completed: _____

Patient Printed Name: _____

Other Information (To be entered by Practice only)

Insurance Name: _____ Insurance Type: _____

Patient has Diabetes: ☐

Patient has Peripheral Vascular Disease (PVD): ☐

Patient has been diagnosed and treated for Covid 19: ☐

Patient has approved the use of their unidentifiable data: ☐