Please circle any of the symptoms you are having.
Please circle N/A if none of these apply: **N/A**

1. **Chills** **Fatigue** **Fever** **Weight gain or loss**

Notes:_____

2. **Blurry vision** **Double vision**

Notes:_____

3. **Nose bleeding** **Headaches** **Changes in your hearing**

Notes:_____

4. **Coughing up blood** **Shortness of breath**

Notes:_____

5. **Chest pain** **Trouble breathing with exercise** **Irregular heartbeat**

Notes:_____

6. **Pain with urination** **Blood in urine** **Leakage of urine**

Notes:_____

7. **Joint swelling** **Muscular weakness** **Joint pain**

Notes:_____

8. **Any numbness or tingling**

Notes:_____

9. **Skin rash**

Notes:_____