Autoimmune Disease Symptom Checklist

Patient information	
Name: Lucy Hong	Age: 26
Gender: female	Medical ID: #0000123456789
Healthcare provider: Dr. Smithe	Date: 1/21/25

Medical history

Has the patient been diagnosed with an autoimmune disease? ☐ Yes ☑ No

If yes, please specify:

Describe any family history or risk factors of autoimmune conditions, as well as any medications currently being taken:

None

Symptom checklist *(patient use)*

Please place a tick next to each of the following symptoms that you have been experiencing recently. For each symptom you tick, please indicate how frequently you experience it. For each symptom you tick, please also rate its recent severity from 1-5 (1 being mild, 5 being severe).

✓	Symptom	Severity	Daily	Weekly	Monthly
☐	Abdominal pain		☐	☐	☐
☐	Digestive issues (irritable bowel syndrome, diarrhea, constipation)		☐	☐	☐
☐	Shortness of breath		☐	☐	☐
☑	Chest pain	3	☐	☐	☑
☐	Vision changes		☐	☐	☐
☐	Numbness/tingling in extremities		☐	☐	☐
☑	Difficulty swallowing	1	☐	☐	☑
☐	Frequent infections		☐	☐	☐
☑	Swollen glands or lymph nodes	5	☐	☐	☑
☐	Thyroid abnormalities		☐	☐	☐
☑	Joint pain/swelling	4	☐	☑	☐
☑	Brain fog/memory or concentration issues/cognitive impairment	2	☑	☐	☐

✓	Symptom	Severity	Daily	Weekly	Monthly
☑	General malaise	2	☐	☑	☐
☑	Fatigue (mental)	3	☑	☐	☐
☑	Fatigue (physical)	2	☑	☐	☐
☑	Rashes, sores, dry or scaly skin	5	☑	☐	☐
☐	Recurring fever		☐	☐	☐
☑	Redness, swelling, and pain in the body (specify where: Face & arms)	2	☐	☑	☐
☐	Unexplained weight loss		☐	☐	☐
☐	Unexplained weight gain		☐	☐	☐
☐	Appetite loss		☐	☐	☐
☑	Muscle aches or weakness	2	☐	☑	☐
☐	Food sensitivity		☐	☐	☐
☐	Hair loss		☐	☐	☐
☐	Sensitivity to cold		☐	☐	☐
☑	Other: Excessive bruising	1	☐	☑	☐
☑	Other: Headaches	2	☐	☑	☐
☑	Other: Insomnia	1	☐	☐	☑
☐	Other:		☐	☐	☐

Comments

Medical professional notes