## **Autoimmune Disease Symptom Checklist**

PERSONAL INFORMATION					
Name:					
Age:					
Gender:					
Date of Checklist:					
AUTOIMMUNE DISEASE HISTORY					
Have you been diagnosed with any autoimmune diseases? Yes No					
If yes, please specify:					
GENERAL SYMPTOMS					
Specific Symptoms (Please check all that apply):					
Abdominal pain					
Digestive issues (diarrhea, constipation)					
Shortness of breath					
Chest pain					
Vision changes					
Numbness or tingling in extremities					
Difficulty swallowing					
Frequent infections					
Swollen glands					
Thyroid abnormalities					
ADDITIONAL INFORMATION					
Are there any other symptoms or concerns you would like to note?					
Frequent infections Swollen glands Thyroid abnormalities ADDITIONAL INFORMATION					

Symptoms		Daily	Weekl	y	Monthly	
Joint pain/swelling						
Shortness of breath						
Vision changes						
Numbness or tingling in extremities						
Frequent infections						
Thyroid abnormalities						
SEVERITY OF SYMPTOMS						
Please rate the severity of each sympton	om on a sca	ale of 1 to 5 (1 b	peing mild, 5	being seve	ere):	
Symptoms	1	2	3	4	5	
Joint pain/swelling						
Shortness of breath						
Vision changes						
Numbness or tingling in extremities						
Frequent infections						
Thyroid abnormalities						
COMMENTS						