

Patient Name: _____

Date: _____

Symptom Survey

The symptoms listed below may be related to your current condition. To insure we have a correct picture of your health, please complete this survey. In the space in front of each item enter (Y) if you are currently experiencing a symptom, or you have had a significant problem with the symptom in the past.

General

1. _____ Fever
2. _____ Chills
3. _____ Night Sweats
4. _____ Loss of Sleep
5. _____ Fatigue
6. _____ Nervousness
7. _____ Weight Loss or Gain
8. _____ Allergies
9. _____ Bleeding Problems
10. _____ Anemia
11. _____ Diabetes
12. _____ Cancer
13. _____ Thyroid Disease/Goiter
14. _____ Alcoholism
15. _____ Drug Abuse

Ear, Eye, Nose, Throat

16. _____ Poor Vision
17. _____ Pain in Eyes
18. _____ Deafness/Difficulty
Hearing
19. _____ Nosebleeds
20. _____ Nose Problems
21. _____ Sinus Trouble
22. _____ Dental Problems
23. _____ Hoarseness
24. _____ Tonsillectomy

Gastrointestinal

25. _____ Poor Appetite
26. _____ Poor Digestion
27. _____ Difficulty Swallowing
28. _____ Belching or Gas
29. _____ Frequent Nausea
30. _____ Vomiting
31. _____ Vomiting Blood
32. _____ Pain over Abdomen
33. _____ Ulcer
34. _____ Black or Bloody Stools
35. _____ Liver Problems
36. _____ Gall Bladder Problems
37. _____ Jaundice
38. _____ Hernia
39. _____ Diarrhea
40. _____ Constipation

41. _____ Hemorrhoids
42. _____ Appendicitis

Men Only

43. _____ Testicular Swelling/Pain
44. _____ Prostate Problems

Women Only

45. _____ Painful Periods
46. _____ Excessive Flow
47. _____ Irregular Cycles
48. _____ Vaginal Burning/Itching
49. _____ Hot Flashes
50. _____ Date last period began
51. _____ Date of last Pap smear

Cardiovascular

52. _____ Irregular Heartbeat
53. _____ High Blood Pressure
54. _____ Pain over Heart
55. _____ Previous Heart Trouble
56. _____ Ankle Swelling
57. _____ Varicose Veins
58. _____ Rheumatic Fever
59. _____ Stroke

Respiratory

60. _____ Difficulty Breathing
61. _____ Chronic Cough
62. _____ Spitting Phlegm
63. _____ Spitting Blood
64. _____ Wheezing/Asthma
65. _____ Pneumonia
66. _____ Tuberculosis

Genitourinary

67. _____ Frequent Urination
68. _____ Painful Urination
69. _____ Blood in Urine
70. _____ Kidney Disease
71. _____ Urinary Infection
72. _____ Inability to Control
Urination
73. _____ Difficulty Starting Urine
Flow
74. _____ Get up at night to urinate

75. _____ Breast Lump or Pain
76. _____ Sexual Difficulties

Skin

77. _____ Itching
78. _____ Bruising
79. _____ Change in Moles
80. _____ Skin Cancer

Neurologic

81. _____ Weakness
82. _____ Twitching
83. _____ Tremors
84. _____ Headache
85. _____ Fainting
86. _____ Dizziness
87. _____ Convulsions
88. _____ Epilepsy/Seizures
89. _____ Numbing/Tingling
90. _____ Arm/Leg Pain
91. _____ Mental Disorder

Musculoskeletal

92. _____ Neck Stiffness/Pain
93. _____ Pain between Shoulders
94. _____ Low Back Pain
95. _____ Swollen Joints
96. _____ Painful Joints
97. _____ Muscle Aches/Soreness
98. _____ Spinal Curves
99. _____ Arthritis

Family History (do not include yourself)

100. _____ Diabetes
101. _____ Thyroid Disease/Goiter
102. _____ Tuberculosis
103. _____ Kidney Disease
104. _____ High Blood Pressure
105. _____ Cancer
106. _____ Muscle, Bone or Nerve
Disease
107. _____ Lung Disease
108. _____ Ulcers
109. _____ Arthritis
110. _____ Seizures/-strokes
111. _____ Heart Disease