

# PATIENT SYMPTOM SURVEY

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ AGE \_\_\_\_\_

WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_ BODY FAT % \_\_\_\_\_

BLOOD PRESSURE \_\_\_\_\_ PULSE \_\_\_\_\_

*This is a confidential patient symptom survey. Please check each condition which is true for you. If the condition does not apply to you or you do not understand a term or if you are not sure if a condition applies to you, then do not check the box. Use common sense. For example, Insomnia once in the last month probably isn't that important and would not be marked. However, Insomnia occurring -2 times per week is notable and would be marked. Please take your time...*

**Remember to hydrate well before the exam.**

## Primary Complaints

- |  |  |  |
|--|--|--|
| <p>090 <input type="checkbox"/> General Good Health</p> <p>091 <input type="checkbox"/> Desires Nutritional &amp; Metabolic Analysis</p> <p>001 <input type="checkbox"/> Skin Disorder</p> <p>002 <input type="checkbox"/> Acne</p> <p>003 <input type="checkbox"/> Psoriasis</p> <p>004 <input type="checkbox"/> Urticaria (Hives)</p> <p>005 <input type="checkbox"/> ADD/ADHD</p> <p>006 <input type="checkbox"/> Allergies</p> <p>007 <input type="checkbox"/> Food Allergy</p> <p>008 <input type="checkbox"/> Sinusitis</p> <p>009 <input type="checkbox"/> Alzheimer's</p> <p>010 <input type="checkbox"/> Poor Concentration/Memory</p> <p>011 <input type="checkbox"/> Parkinson's Disease</p> <p>012 <input type="checkbox"/> Anemia</p> <p>013 <input type="checkbox"/> Arthritic Disorder</p> <p>014 <input type="checkbox"/> Osteoporosis</p> <p>015 <input type="checkbox"/> Asthma</p> <p>016 <input type="checkbox"/> Emphysema</p> <p>035 <input type="checkbox"/> Chronic Fatigue</p> <p>036 <input type="checkbox"/> Circulatory Disorder</p> <p>037 <input type="checkbox"/> Heart Disease</p> <p>038 <input type="checkbox"/> High Cholesterol</p> <p>039 <input type="checkbox"/> High Blood Pressure</p> <p>040 <input type="checkbox"/> Low Blood Pressure</p> <p>041 <input type="checkbox"/> Tachycardia (High Heart Rate)</p> <p>042 <input type="checkbox"/> Numbness</p> <p>043 <input type="checkbox"/> Constipation</p> | <p>044 <input type="checkbox"/> Indigestion</p> <p>045 <input type="checkbox"/> D Ulcerative Colitis</p> <p>046 <input type="checkbox"/> Depression</p> <p>047 <input type="checkbox"/> Diabetes Mellitus</p> <p>048 <input type="checkbox"/> Hypoglycemia</p> <p>049 <input type="checkbox"/> Dizziness/Balance Problem.</p> <p>050 <input type="checkbox"/> Ear Infection</p> <p>051 <input type="checkbox"/> Epstein Barr</p> <p>052 <input type="checkbox"/> Eye Problems</p> <p>053 <input type="checkbox"/> Cataracts</p> <p>054 <input type="checkbox"/> Glaucoma</p> <p>055 <input type="checkbox"/> Macular Degeneration</p> <p>056 <input type="checkbox"/> Fever</p> <p>057 <input type="checkbox"/> Fibromyalgia</p> <p>058 <input type="checkbox"/> Gallbladder Disorder</p> <p>059 <input type="checkbox"/> Gout</p> <p>060 <input type="checkbox"/> Headaches</p> <p>061 <input type="checkbox"/> Hearing Loss</p> <p>062 <input type="checkbox"/> Infertility, male</p> <p>063 <input type="checkbox"/> Prostate Disorder</p> <p>064 <input type="checkbox"/> Liver Disease</p> <p>065 <input type="checkbox"/> Hepatitis</p> <p>066 <input type="checkbox"/> Hepatitis B</p> <p>067 <input type="checkbox"/> Hepatitis C</p> <p>068 <input type="checkbox"/> Kidney/Bladder Problems</p> <p>069 <input type="checkbox"/> Hyperthyroid</p> <p>070 <input type="checkbox"/> Hypothyroid</p> <p>071 <input type="checkbox"/> Lupus</p> <p>072 <input type="checkbox"/> Infertility, female</p> <p>073 <input type="checkbox"/> Interstitial Cystitis</p> | <p>074 <input type="checkbox"/> Irregular Menstrual Cycle</p> <p>075 <input type="checkbox"/> Menopausal Symptoms</p> <p>076 <input type="checkbox"/> Hot Flashes</p> <p>077 <input type="checkbox"/> Mental Disorder</p> <p>078 <input type="checkbox"/> Insomnia</p> <p>079 <input type="checkbox"/> Mouth/Throat/Tongue</p> <p>080 <input type="checkbox"/> Canker Sores</p> <p>081 <input type="checkbox"/> Overweight</p> <p>082 <input type="checkbox"/> Underweight</p> <p>083 <input type="checkbox"/> Sexual Disorder</p> <p>084 <input type="checkbox"/> Spinal Problems</p> <p>085 <input type="checkbox"/> Obesity</p> <p>086 <input type="checkbox"/> GERD</p> <p>087 <input type="checkbox"/> HIV infection</p> <p>017 <input type="checkbox"/> Cancer</p> <p>018 <input type="checkbox"/> Breast</p> <p>019 <input type="checkbox"/> Prostate</p> <p>020 <input type="checkbox"/> Lung</p> <p>021 <input type="checkbox"/> Colon/Rectal</p> <p>022 <input type="checkbox"/> Skin</p> <p>023 <input type="checkbox"/> Leukemia</p> <p>024 <input type="checkbox"/> Lymphoma</p> <p>025 <input type="checkbox"/> Brain Tumor</p> <p>026 <input type="checkbox"/> Other</p> <p>088 <input type="checkbox"/> Crohn's Disease</p> <p>089 <input type="checkbox"/> Irritable Bowel Syndrome</p> |
|--|--|--|

Please state your most significant concern(s): \_\_\_\_\_

## ***General Health***

- 100  Base of fingernails are pink  
101  Base of fingernails are purple  
102  Fingernails have ridges or white spots  
103  Fingernails are soft  
104  Fingernails are splitting  
105  Fingernails peel  
106  Pale fingernail beds  
107  Black out easily  
108  Balance problems  
109  Difficulty walking  
110  Have tattoos  
111  Brittle hair  
112  Dry hair  
113  Thin hair  
114  Hair loss  
115  Drink alcoholic beverages daily  
116  Drink less than 8 glasses of water a day  
117  Currently on Chemotherapy  
118  Currently on radiation treatment  
119  Had chemotherapy in the past  
120  Had radiation treatments in the past  
121  Gained over 20 lbs in the last 12 months  
122  Somewhat Overweight  
123  Somewhat Underweight  
124  Unexplained weight loss of over 20lbs within the last 4 months  
125  Energy level is worse than it was 5 years ago  
127  Sleep less than 6 hours per night  
128  Unable to recall dreams the next day  
129  Sensitive to chemicals, paint, fumes, cologne  
130  Had blood transfusion in the past  
131  Had transplant in the past  
132  Had a major accident or injury (i.e. auto, work, other)

## ***Lifestyle Habits***

- 370  Drins alcohol  
371  Drink caffeinated coffee  
372  Drink caffeinated pop/soda  
373  Drink caffeinated tea  
374  Drink decaffeinated coffee  
375  Drink decaffeinated Pop/soda  
376  Drink decaffeinated tea  
377  Drink more than 3 cups of coffee per day  
378  Drink more than 3 cups of tea per day  
379  Drink 1 or more pop/sodas per day  
388  Drink diet pop/soda  
380  Drink beverages from a can  
381  Have more than 5 alcoholic drinks per week  
382  Currently smoke  
383  Quit smoking in the last 5 years  
384  Smoked for more than 5years  
385  Smoke more than 1 pack per day  
126  Rarely exercises  
133  Regularly exercises  
386  Take Vitamins  
134  Vegetarian  
135  Eat no red meat  
136  Eat no meat, no dairy  
387  Frequent use of artificial sweeteners

## ***Surgeries***

- 700  Tonsillectomy and/or Adenoids  
701  Appendix  
702  Gallbladder  
703  Thyroid  
715  Radiated thyroid  
708  Cancer  
704  Hysterectomy, complete  
705  Hysterectomy, partial  
706  Tubal ligation  
707  Breast implants  
709  Coronary by-pass  
710  Spinal surgery  
711  Extremity surgery  
71 2  Hip replacement  
713  Knee replacement

### **Gastrointestinal**

- 265  4-5 bowel movements per week
- 266  3 or fewer bowel movements per week
- 267  6 or more bowel movements per week
- 268  Black tarry stools
- 269  Pale or yellow colored stool
- 270  Blood stools
- 271  Constipation
- 272  Hemorrhoids
- 273  Loose bowel movements
- 274  Frequent diarrhea
- 275  Frequent nausea
- 276  Frequent vomiting

- 277  Abdominal gas
- 278  Belching and burping after eating
- 279  Bloating after eating
- 280  Severe abdominal pains
- 281  Stomach ulcers
- 282  Uses digestive aids
- 283  Uses laxatives
- 284  Immediate indigestion upon eating
- 285  Indigestion in 2 hours or more after meals
- 286  Indigestion within 1 hour after meals
- 287  Difficulty swallowing

- 289  Eat when nervous
- 290  Excessive hunger
- 291  Poor appetite
- 292  Experiences fainting spells when hungry
- 293  Feels shaky when hungry
- 294  Frequently drowsy after eating a meal
- 295  Gall bladder disease
- 296  Has had intestinal worms
- 297  Reflux/Hiatal hernia
- 298  Liver disease
- 299  Irritable Bowel Syndrome
- 288  Eating relieves fatigue

### **Respiratory**

- 485  Catch severe colds
- 486  Chronic chest condition
- 487  Chronic cough
- 488  Constant runny nose
- 489  COPD
- 490  Difficulty breathing

- 491  Frequent colds
- 492  Frequent nose bleeds
- 493  Frequent sinus infections
- 494  Frequent stuffy nose
- 495  Hay fever
- 496  Nasal polyps

- 497  Night sweats
- 498  Post nasal drip
- 499  Sneezing spells
- 500  Spit up blood
- 501  Spits up phlegm
- 502  Wheezes

### **Mouth and Throat**

- 400  Bad breath
- 401  Bitter taste in the mouth in the morning
- 402  Dry mouth
- 403  Excessive saliva
- 404  Sores or cracks in the corners of the mouth
- 405  Glands often swell
- 406  Frequent canker sores

- 407  Frequent fever blisters
- 408  Frequent sore throats
- 409  Frequently has a sore tongue
- 410  Sore gums
- 411  Swollen gums
- 412  Swollen tongue
- 413  Tongue burns
- 414  Tongue has grooves or fissures

- 415  Tongue is coated
- 416  Gums bleed when brushing teeth
- 417  Toothaches
- 418  Amalgam dental fillings
- 420  Other dental fillings (gold, composite, etc)
- 419  Has had root canal(s)

### **Endocrine**

- 245  Coarse hair
- 246  Coarse skin
- 247  Diabetic
- 248  Excessive thirst

- 249  Frequently feel cold
- 250  Frequently feel hot
- 251  Get lightheaded when standing quickly
- 252  Heals slowly

- 253  Unusually jumpy or nervous
- 254  Unusually tired most of the time

- 190  Cold Feet
- 191  Cold hands
- 192  Experience shortness of breath while sitting still
- 193  Heart skips beats
- 194  Tendency of High blood Pressure

- 520  Bruise easily
- 521  Excessive perspiration
- 522  Frequent goose bumps
- 523  Has acne
- 524  Has Psoriasis
- 525  Hives

- 220  Discharge from ears
- 221  Hard of hearing

- 320  Bloodshot eyes
- 321  Blurred vision
- 322  Cross eyes
- 323  Eye pain
- 324  Eyes feel gritty

- 350  Corns
- 351  Frequent foot cramps
- 352  Heel spurs

- 440  Bites nails
- 441  Frequent muscle soreness
- 442  Muscle spasms
- 443  Muscle weakness
- 444  Tremors
- 445  Frequent headaches
- 446  Often Dizzy
- 447  Frequently feels faint
- 448  Has Epilepsy
- 449  Has motion sickness

**Cardiovascular**

- 195  Leg cramps during bedtime
- 196  Leg cramps during daytime
- 197  Low blood pressure at times
- 198  Pain in leg/hips when walking
- 199  Frequent swollen ankles

**Skin**

- 526  Itchy skin
- 527  Problems with Eczema
- 528  Has moles which are changing in size and/or color
- 529  Skin eruptions

**Ears**

- 222  Punctured ear drum
- 223  Recurrent ear infection

**Eyes**

- 325  Eyes watery
- 326  Mild Glaucoma
- 327  Far Sighted
- 328  Developing cataracts

**Feet**

- 353  Painful feet
- 354  Plantar warts

**Neuromuscular**

- 450  Has Osteoarthritis
- 451  Has Rheumatism
- 452  Rheumatoid Arthritis
- 453  Joint stiffness in the morning
- 454  Swollen joints
- 455  Leg pain at rest
- 456  Spinal curvature
- 457  Low back pain
- 458  Neck pain

- 200  Pain in the heart or chest
- 201  Spells of rapid heart rate
- 202  Troubled with blood clots
- 203  Unusually slow pulse rate
- 204  Varicose veins

- 530  Skin is rough, especially on the back of the arms
- 531  Skin is tender
- 532  Sores that heal slowly
- 533  Troubled with boils
- 534  Dry skin

- 224  Ringing or noises in the ears

- 329  Mild Macular degeneration
- 330  Itchy eyes
- 331  Near sighted
- 332  Dry Eyes

- 355  Swelling in the feet/ankles
- 356  Plantar fasciitis
- 357  Fungal infection

- 459  Pain between the shoulders
- 460  Shoulder/arm pain
- 461  Numbness/tingling in the body
- 462  Sleep walks
- 463  Stutters or stammers
- 464  Nerve pain

- 150  Afraid to eat anywhere except home
- 151  Always needs someone to advise
- 152  Cry often
- 153  Difficulty concentrating
- 154  Difficulty falling asleep
- 155  Difficulty staying asleep
- 156  Easily angered
- 157  Feelings are easily hurt

### ***Behavior Problems***

- 158  Frequently becomes scared for no reason
- 159  Frequently miserable or blue
- 160  Have to be on guard even with friends
- 161  Often annoyed by people
- 162  Recurrent bad dreams
- 163  Sometimes wishes to be dead or away from it all
- 164  Upset by criticism
- 165  Poor memory

- 166  Scared to be alone
- 167  Strange people or places cause fear
- 168  Under considerable emotional stress
- 169  Unhappy when other are happy
- 170  Brain fog

- 555  Urinate more than 2 times per night
- 556  Bed wetting
- 557  Blood in the urine
- 558  Difficulty starting urination

### ***Urinary***

- 559  Painful urination
- 560  Frequent urination.
- 561  Troubled by urgent urination
- 562  Incontinence when sneezing or laughing
- 563  Loses bladder control

- 564  Frequent bladder infections
- 565  Frequent kidney infections
- 566  Kidney stones

- 585  Difficulty completing intercourse
- 586  Difficulty getting or keeping an erection
- 587  Discharge from the urethra

### ***Men Only***

- 588  Had a vasectomy
- 589  Had difficulty fathering children
- 590  Lumps in the testicles
- 591  Painful genitals
- 592  Prostate troubles

- 593  Sores on external genitalia
- 594  Herpes
- 595  Sexual diseases

- 610  Heavy hair growth on face or body
- 611  Cycles are every 27-29 days
- 612  Abnormal cycle >29 days and/or <26 days
- 613  PMS
- 614  Menstrual cramps
- 615  Painful periods
- 616  Acne worse at menstruation
- 617  Excessive menstrual flow
- 618  Retains fluid during period s

### ***Women Only***

- 619  Pre-menstrual depression
- 620  Currently taking birth control medication
- 621  Has taken birth control medication more than 1 year
- 622  s taken birth control medication within the last year
- 623  Has had miscarriage
- 624  Hot flashes
- 625  Takes hormone replacement medication

- 627  Diminished sexual desire
- 628  Painful intercourse
- 629  Poor or infrequent orgasm
- 630  Lumps in the breasts
- 631  Tender breasts
- 633  Vaginal discharge
- 634  Bloody spotting discharge
- 635  Yeast infections
- 636  Sores on external genitalia
- 637  Herpes
- 638  Sexual diseases

## *Medications*

Please list all drugs you are currently taking including over the counter drugs, aspirin, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all drugs taken within the last year including over the counter drugs, antibiotics, aspirin, inhalers, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all vitamins/herbs/supplements you are currently taking. Also, list how much of each supplement you are taking.

<u>VITAMIN/HERB</u>	<u>FOR WHAT:</u>	<u>HOW LONG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all tattoos you have (Location, Date, Sterile/Not, Infection, Hepatitis Testing)

_____	_____	_____
_____	_____	_____

# FOOD DIARY

Please list what you have eaten and drank over the past week. Include all snacks and beverages (alcohol, coffee, tea, etc.). Try to remember portion sizes. Don't fret too much, do the best you can.

\_\_\_\_ DAY  
Breakfast \_\_\_\_\_  
Snack \_\_\_\_\_  
Lunch \_\_\_\_\_  
Snack \_\_\_\_\_  
Dinner \_\_\_\_\_  
Snack \_\_\_\_\_

\_\_\_\_ DAY  
Breakfast \_\_\_\_\_  
Snack \_\_\_\_\_  
Lunch \_\_\_\_\_  
Snack \_\_\_\_\_  
Dinner \_\_\_\_\_  
Snack \_\_\_\_\_

\_\_\_\_ DAY  
Breakfast \_\_\_\_\_  
Snack \_\_\_\_\_  
Lunch \_\_\_\_\_  
Snack \_\_\_\_\_  
Dinner \_\_\_\_\_  
Snack \_\_\_\_\_

\_\_\_\_ DAY  
Breakfast \_\_\_\_\_  
Snack \_\_\_\_\_  
Lunch \_\_\_\_\_  
Snack \_\_\_\_\_  
Dinner \_\_\_\_\_  
Snack \_\_\_\_\_

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Breakfast \_\_\_\_\_  
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Snack \_\_\_\_\_

\_\_\_\_ DAY  
Breakfast \_\_\_\_\_  
Snack \_\_\_\_\_  
Lunch \_\_\_\_\_  
Snack \_\_\_\_\_  
Dinner \_\_\_\_\_  
Snack \_\_\_\_\_

\_\_\_\_ DAY  
Breakfast \_\_\_\_\_  
Snack \_\_\_\_\_  
Lunch \_\_\_\_\_  
Snack \_\_\_\_\_  
Dinner \_\_\_\_\_  
Snack \_\_\_\_\_