

PATIENT SYMPTOM SURVEY



DATE _____

PATIENT'S NAME _____ AGE _____

WEIGHT _____ HEIGHT _____ BLOOD PRESSURE _____ PULSE _____ O2 _____

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time...

Primary Complaints

- | | | |
|--|--|--|
| <p>097 <input type="checkbox"/> Abdominal Pain R10.9</p> <p>005 <input type="checkbox"/> ADD/ADHD F90.1/F90.9</p> <p>144 <input type="checkbox"/> ALS (Lou Gehrig's Disease) G12.21</p> <p>012 <input type="checkbox"/> Anemia D64.9</p> <p>013 <input type="checkbox"/> Arthritic Disorder M12.9</p> <p>181 <input type="checkbox"/> Brain Aneurysm I61.9</p> <p>094 <input type="checkbox"/> Breast Cancer (male) C50.929</p> <p>053 <input type="checkbox"/> Cataracts H26.9</p> <p>036 <input type="checkbox"/> Circulatory Disorder I99.9</p> <p>088 <input type="checkbox"/> Crohn's disease K50.90</p> <p>091 <input type="checkbox"/> Desires Nutritional and Metabolic Analysis</p> <p>050 <input type="checkbox"/> Ear Infection H65.90</p> <p>016 <input type="checkbox"/> Emphysema J43.9</p> <p>056 <input type="checkbox"/> Fever R50.9</p> <p>090 <input type="checkbox"/> General Good Health</p> <p>171 <input type="checkbox"/> Goiter E04.9</p> <p>061 <input type="checkbox"/> Hearing Loss H91.90</p> <p>065 <input type="checkbox"/> Hepatitis K71.6</p> <p>087 <input type="checkbox"/> HIV Infection B20</p> <p>029 <input type="checkbox"/> Hyperglycemia (high blood sugar) R73.09</p> <p>148 <input type="checkbox"/> Hypocholesterolemia (Low Cholesterol) E78.6</p> <p>070 <input type="checkbox"/> Hypothyroid E03.9</p> <p>062 <input type="checkbox"/> Infertility, male N46.9</p> <p>074 <input type="checkbox"/> Irregular Menstrual Cycle N92.6</p> <p>023 <input type="checkbox"/> Leukemia w/o remission C95.90</p> <p>040 <input type="checkbox"/> Low blood pressure I95.9</p> <p>142 <input type="checkbox"/> Lupus, non-systemic L93.0</p> <p>722 <input type="checkbox"/> Malaise</p> <p>077 <input type="checkbox"/> Mental Disorder F99</p> <p>079 <input type="checkbox"/> Mouth/Throat/Tongue</p> <p>726 <input type="checkbox"/> Myopia</p> <p>729 <input type="checkbox"/> Nephrolithiasis (Kidney Stones)</p> <p>085 <input type="checkbox"/> Obesity E66.9</p> <p>014 <input type="checkbox"/> Osteoporosis M81.0</p> <p>732 <input type="checkbox"/> Pain in Limbs</p> <p>145 <input type="checkbox"/> Polymyalgia Rheumatica M35.3</p> | <p>098 <input type="checkbox"/> Abdominal Gas/Bloating R14.0</p> <p>006 <input type="checkbox"/> Allergies (unspecified) J30.9</p> <p>009 <input type="checkbox"/> Alzheimer's G30.9</p> <p>027 <input type="checkbox"/> Anxiety Disorder F41.9</p> <p>015 <input type="checkbox"/> Asthma J45.909</p> <p>025 <input type="checkbox"/> Brain Tumor, malignant C71.9</p> <p>017 <input type="checkbox"/> Cancer</p> <p>026 <input type="checkbox"/> Cervical Cancer C53.9</p> <p>021 <input type="checkbox"/> Colon/Rectal Cancer C18.9</p> <p>092 <input type="checkbox"/> Currently Pregnant Z33.1</p> <p>047 <input type="checkbox"/> Diabetes Mellitus E11.9</p> <p>034 <input type="checkbox"/> Eczema L25.9</p> <p>051 <input type="checkbox"/> Epstein Barr B27.90</p> <p>057 <input type="checkbox"/> Fibromyalgia M79.7</p> <p>086 <input type="checkbox"/> GERD K21.9</p> <p>059 <input type="checkbox"/> Gout M10.9</p> <p>037 <input type="checkbox"/> Heart Disease I51.9</p> <p>066 <input type="checkbox"/> Hepatitis B B16.9</p> <p>076 <input type="checkbox"/> Hot flashes N95.1</p> <p>720 <input type="checkbox"/> Hypertension (High Blood Pressure) I10</p> <p>048 <input type="checkbox"/> Hypoglycemia (low blood sugar) E16.2</p> <p>044 <input type="checkbox"/> Indigestion K30</p> <p>078 <input type="checkbox"/> Insomnia G47.00</p> <p>089 <input type="checkbox"/> Irritable Bowel Syndrome K58.9</p> <p>095 <input type="checkbox"/> Leukemia w/ remission C95.91</p> <p>020 <input type="checkbox"/> Lung Cancer C34.90</p> <p>024 <input type="checkbox"/> Lymphoma, malignant C85.89</p> <p>075 <input type="checkbox"/> Menopausal Symptoms N95.1</p> <p>140 <input type="checkbox"/> Migraines G43.909</p> <p>143 <input type="checkbox"/> Multiple Sclerosis G35</p> <p>727 <input type="checkbox"/> Nasal Polyp</p> <p>095 <input type="checkbox"/> Nosebleed</p> <p>730 <input type="checkbox"/> Orgasm, poor/infrequent</p> <p>026 <input type="checkbox"/> Other Cancers</p> <p>733 <input type="checkbox"/> Painful Urination</p> <p>010 <input type="checkbox"/> Poor Concentration/Memory F07.8</p> | <p>002 <input type="checkbox"/> Acne L70.8</p> <p>007 <input type="checkbox"/> Allergic Rhinitis from food J30.5</p> <p>099 <input type="checkbox"/> Amenorrhea M91.2</p> <p>028 <input type="checkbox"/> Autism F84.0</p> <p>096 <input type="checkbox"/> Bladder Disorder N32.9</p> <p>018 <input type="checkbox"/> Breast Cancer (female) C50.919</p> <p>080 <input type="checkbox"/> Canker Sores K12.0</p> <p>035 <input type="checkbox"/> Chronic Fatigue R53.82</p> <p>043 <input type="checkbox"/> Constipation K59.00</p> <p>046 <input type="checkbox"/> Depression F32.9</p> <p>049 <input type="checkbox"/> Dizziness/Balance problems R42</p> <p>033 <input type="checkbox"/> Edema R60.9</p> <p>052 <input type="checkbox"/> Eye Problems H57.13</p> <p>058 <input type="checkbox"/> Gallbladder Disorder K82.9</p> <p>054 <input type="checkbox"/> Glaucoma H40.9</p> <p>060 <input type="checkbox"/> Headaches R51</p> <p>179 <input type="checkbox"/> Hemochromatosis E83.119</p> <p>067 <input type="checkbox"/> Hepatitis C B17.10</p> <p>038 <input type="checkbox"/> Hypercholesterolemia (High Cholesterol) E78.0</p> <p>069 <input type="checkbox"/> Hyperthyroid E05.90</p> <p>721 <input type="checkbox"/> Hypotension (Low Blood Pressure) I95.9</p> <p>072 <input type="checkbox"/> Infertility, Female N97.9</p> <p>073 <input type="checkbox"/> Interstitial Cystitis N30.11</p> <p>068 <input type="checkbox"/> Kidney Disorder N28.9</p> <p>064 <input type="checkbox"/> Liver Disease K76.9</p> <p>071 <input type="checkbox"/> Lupus, systemic M32.10</p> <p>055 <input type="checkbox"/> Macular Degeneration H35.30</p> <p>723 <input type="checkbox"/> Menorrhagia</p> <p>724 <input type="checkbox"/> Motion Sickness</p> <p>725 <input type="checkbox"/> Myalgia</p> <p>728 <input type="checkbox"/> Nephritis</p> <p>042 <input type="checkbox"/> Numbness/Paresthesia R20.9</p> <p>731 <input type="checkbox"/> Osteoarthritis</p> <p>081 <input type="checkbox"/> Overweight E66.3</p> <p>011 <input type="checkbox"/> Parkinson's Disease G20</p> <p>181 <input type="checkbox"/> Post stroke/brain aneurysm</p> |
|--|--|--|

- 613 Premenstrual Syndrome
- 735 Prostate Cancer - screening
- 178 Raynaud's syndrome I73.00
- 737 Salivary Secretions
- 083 Sexual Disorder F66
- 008 Sinusitis J01.90
- 94 Skin Rash
- 084 Spinal Problems M53.9
- 742 Stress Incontinence, male
- 041 Tachycardia (High Heart Rate) R00.0
- 745 Thoracalgia
- 030 Type 1 Diabetes E10.9
- 082 Underweight R63.6
- 004 Urticaria (Hives) L50.9
- 098 Varicosities
- 099 Wheezing

- 734 Presbyopia
- 063 Prostate Disorder N42.9
- 736 Rheumatism
- 146 Scleroderma M34.9
- 739 Shortness of Breath
- 022 Skin Cancer C44.90
- 096 Sneezing
- 463 Stammering/Stuttering
- 097 Swollen Joints
- 744 Tender Breasts
- 746 Toothache
- 031 Type 2 Diabetes E11.65
- 748 Urethra Discharge
- 750 Vaginal Discharge
- 752 Vertigo

- 019 Prostate Cancer C61
- 003 Psoriasis L40.8
- 141 Rheumatoid Arthritis M06.9
- 738 Scoliosis
- 093 Shingles B02.9
- 001 Skin Disorder L25.9
- 740 Sore Throat
- 741 Stress Incontinence, female
- 743 Syncope
- 180 Thalassemia D56.8
- 747 Tympanic Membrane (Ear Ache)
- 045 Ulcerative Colitis K51.90
- 749 Urinary Frequency
- 751 Vaginal Yeast Infection
- 753 Viral Warts

If necessary, please state your most significant concern...

General Health

- 226 Breast Cancer - Screening
- 100 Base of fingernails are pink
- 111 Brittle hair
- 118 Currently on Radiation treatments
- 116 Drinks less than 8 glasses of water per day
- 756 Energy level is the same as it was 5 years ago
- 103 Fingernails are soft
- 121 Gained over 20 lbs within in the last 12 months
- 758 Has had Chemotherapy within the last 3 months
- 130 Had Blood Transfusion in the Past
- 148 Is overweight
- 106 Pale fingernail beds
- 129 Sensitive to chemicals, paint, exhaust fumes, cologne
- 123 Somewhat Underweight
- 187 Family history of Alcoholism
- 186 Family history of Diabetes
- 149 Had Chemotherapy in the last year
- 175 Has been out of the country recently
- 183 Has had a Hepatitis vaccine within the last 2 years
- 139 Toxic Chemical Exposure

- 138 Anti Rejection Drugs
- 101 Base of fingernails are purple
- 219 Breast Cancer - History
- 109 Difficulty walking
- 112 Dry hair
- 125 Energy level is worse than it was 5 years ago
- 104 Fingernails are splitting
- 114 Hair loss
- 120 Has had Radiation treatments in the past
- 131 Had Transplant in the Past
- 754 Is underweight
- 757 Pink fingernail beds
- 127 Sleeps less than 6 hours per night
- 113 Thin hair
- 184 Family history of Cancer
- 185 Family history of Heart Disease
- 176 Had childhood vaccinations
- 177 Has been vaccinated in the last 12 months
- 182 Has had a pneumonia vaccine in the last year

- 108 Balance Problems
- 107 Blacks out easily
- 117 Currently on Chemotherapy
- 115 Drinks alcoholic beverage(s) every day
- 755 Energy level is better than it was 5 years ago
- 102 Fingernails have ridges or white spots
- 105 Fingernails peel
- 119 Has had Chemotherapy in the past
- 132 Had a major accident or injury
- 110 Has tattoos
- 124 Lost over 20 lbs within the last 4 months
- 126 Rarely exercises
- 122 Somewhat Overweight
- 128 Unable to recall dreams the next day
- 188 Family history of Depression
- 189 Family history of Obesity
- 148 Had Radiation therapy in the last year
- 147 Has had a flu shot in the last year
- 137 Sleep Apnea

Allergies

- 206 Dairy
209 Gluten
212 Ragweed
215 Sulfa Drugs
218 Other allergies
- 207 Eggs
210 Mold
213 Shellfish
216 Tree Nuts
- 208 Garlic
211 Peanut
214 Soy
217 Wheat

Behavior Patterns

- 150 Afraid to eat anywhere except home
152 Cries often
155 Difficulty staying asleep
158 Frequently becomes scared for no reason
161 Often annoyed by people
166 Scared to be alone
168 Under considerable emotional stress
- 151 Always needs someone to advise
153 Difficulty concentrating
156 Easily angered
159 Frequently miserable or blue
165 Poor memory
163 Sometimes wishes to be dead or away from it all
169 Unhappy when others are happy
- 170 Brain Fog
154 Difficulty falling asleep
157 Feelings are easily hurt
160 Has to be on guard even with friends
162 Recurrent bad dreams
167 Strange people or places cause fear
164 Upset by criticism

Cardiovascular

- 197 At Times Low Blood Pressure
192 Experiences shortness of breath while sitting still
205 Heart palpitations
196 Leg cramps during daytime
201 Spells of rapid heart rate
203 Unusually slow heart rate (Bradycardia)
- 190 Cold feet
199 Frequent swollen ankles
039 High blood pressure
198 Pain in leg/hips when walking
194 Tendency of High Blood Pressure
204 Varicose veins
- 191 Cold hands
193 Heart skips beats
195 Leg cramps during bedtime
200 Pains in the heart or chest
202 Troubled with blood clots

Ears

- 220 Discharge from ears
223 Recurrent ear infections
- 221 Hard of hearing
224 Ringing or noises in the ears
- 222 Punctured ear drum
225 Tinnitus

Endocrine

- 245 Coarse hair
248 Excessive thirst
251 Gets lightheaded when standing quickly
253 Unusually jumpy or nervous
- 246 Coarse skin
249 Frequently feels cold
252 Heals slowly
254 Unusually tired most of the time
- 247 Diabetic
250 Frequently feels hot
255 Swollen Lymph glands

Eyes

- 320 Bloodshot eyes
332 Dry Eyes
325 Eyes water
330 Itchy eyes
329 Mild Macular Degeneration
- 321 Blurred Vision
323 Eye pain
327 Far sighted
328 Mild Cataracts
331 Near sighted
- 322 Cross eyes
324 Eyes feel gritty
759 Has or has had cataracts
326 Mild Glaucoma

Feet

- 350 Corns
352 Heel spurs
354 Plantar warts
- 351 Frequent foot cramps
353 Painful feet
355 Swelling in the feet and/or ankles
- 357 Fungal Infection
356 Plantar Fascitis

Gastrointestinal

- 266 3 or less bowel movements per week
277 Abdominal gas
279 Bloating after eating
300 Diverticulitis
289 Eats when nervous
293 Feels shaky when hungry
276 Frequent vomiting
302 Greasy foods cause indigestion
272 Hemorrhoids (piles)
286 Indigestion within 1 hour after meals
273 Loose bowel movements
297 Reflux/Hiatal Hernia
271 Tends to constipation
265 4-5 bowel movements per week
278 Belching and burping after eating
270 Bloody Stools
301 Diverticulosis
290 Excessive hunger
274 Frequent diarrhea
294 Frequently drowsy after eating a meal
760 Has constipation
284 Immediate indigestion upon eating
299 Irritable Bowel
269 Pale or yellow colored stool
280 Severe abdominal pains
282 Uses digestive aids
267 6 or more bowel movements per week
268 Black tarry stools
287 Difficulty swallowing
288 Eating relieves fatigue
292 Experiences fainting spells when hungry
275 Frequent nausea
295 Gall bladder disease
296 Has had intestinal worms
285 Indigestion in 2 hours or more after meals
298 Liver disease
291 Poor appetite
281 Stomach ulcers
283 Uses laxatives

Lifestyle Habits

- 389 Anorexia R63.0
382 Currently smokes
372 Drinks caffeinated pop/soda
392 Drinks coffee
388 Drinks diet pop/soda
379 Drinks 1 or more pop/sodas per day
136 Eats no meat, no dairy
174 Had 4 alcoholic drinks in one day less than 3 months ago
172 Never had 4 alcoholic drinks in one day
384 Smoked for more than 5 years
134 Vegetarian
342 Home water is filtered
345 Home pipes are copper
348 Home renovations within the last year
361 Has worked around industrial solvents, chemicals or pesticides
390 Bulimia
370 Drinks alcohol
373 Drinks caffeinated tea
374 Drinks decaffeinated coffee
377 Drinks more than 3 cups of coffee per day
380 Drinks beverages from a can
135 Eats no red meat
173 Had 4 alcoholic drinks in one day more than 3 months ago
383 Quit smoking in the last 5 years
385 Smokes more than 1 pack per day
340 Home has well water
343 Home pipes are steel
346 Home pipes are PEX
349 Uses chlorine bleach or other heavy duty chemicals
391 Craves Sugars/starches
371 Drinks caffeinated coffee
375 Drinks Decaffeinate Pop/Soda
376 Drinks decaffeinated tea
378 Drinks more than 3 cups of tea per day
393 Drinks tea
387 Frequent use of Artificial Sweeteners
381 Has more than 5 alcoholic drinks per week
133 Regularly exercises
386 Takes vitamins
341 Home has city water
344 Home pipes are PVC
347 Home built prior to 1978
360 Has worked in plumbing, automotive or metallurgic industry

Mouth and Throat

- 418 Amalgam dental fillings
420 Dental Fillings (gold, composite etc.)
406 Frequent canker sores
409 Frequently has a sore tongue
400 Bad breath
402 Dry mouth
407 Frequent fever blisters
405 Glands often swell
401 Bitter taste in the mouth in the morning
403 Excessive saliva
408 Frequent sore throats
416 Gums bleed when brushing teeth

- 419 Have had root canals
 404 Sores or cracks in the corners of the mouth
 413 Tongue burns
 417 Toothaches

- 420 Other dental fillings
 411 Swollen gums
 414 Tongue has grooves or fissures

- 410 Sore gums
 412 Swollen tongue
 415 Tongue is coated

Neuromuscular

- 440 Bites nails
 447 Frequently feels faint
 450 Has Osteoarthritis
 455 Leg pain at rest
 443 Muscle weakness
 461 Numbness/tingling in the body
 452 Rheumatoid Arthritis
 456 Spinal curvature
 444 Tremors/Shakes

- 445 Frequent headaches
 448 Has Epilepsy
 451 Has Rheumatism
 457 Low back pain
 458 Neck pain
 446 Often dizzy
 460 Shoulder/arm pain
 761 Stutters or stammers

- 441 Frequent muscle soreness
 449 Has Motion Sickness
 453 Joint stiffness in the morning
 442 Muscle spasms
 464 Nerve Pain
 459 Pain between the shoulders
 462 Sleep walks
 454 Swollen joints

Respiratory

- 485 Catches severe colds
 488 Constant runny nose
 491 Frequent colds
 494 Frequent stuffy nose
 496 Nasal polyps
 500 Spits up blood

- 486 Chronic chest condition
 489 COPD
 492 Frequent nose bleeds
 503 Has asthma
 498 Post nasal drip
 501 Spits up phlegm

- 487 Chronic cough
 490 Difficulty breathing
 493 Frequent sinus infections
 495 Hay fever
 499 Sneezing spells
 502 Wheezes

Women Only

- 497 Night sweats
 616 Acne worse at menstruation
 647 Breast Fibroids
 648 Currently breastfeeding
 643 D & C
 617 Excessive menstrual flow
 621 Has taken birth control medication for more than one year
 637 Herpes infection
 609 Mastitis
 646 Ovarian Fibroids
 629 Poor or infrequent orgasm
 638 Sexual diseases
 644 Tubal Pregnancy
 762 Vagina dryness

- 612 Abnormal cycle >29 days and/or <26 days
 634 Bloody spotting discharge
 707 Breast Implants
 620 Currently taking birth control medication
 627 Diminished sexual desire
 636 External genital sores
 622 Has taken birth control medication within the last year
 632 Hysterectomy
 614 Menstrual cramps
 628 Painful intercourse
 619 Pre-menstrual depression
 625 Takes hormone replacement medication
 645 Uterine Fibroids
 635 Yeast infections

- 642 Abortion
 641 Breast Augmentation
 640 Breast Reduction
 611 Cycles are every 27-29 days
 639 Endometriosis
 623 Has had miscarriage
 610 Heavy hair growth on face or body
 630 Lumps in the breasts
 624 Mild to Moderate Hot Flashes
 615 Painful periods
 618 Retains fluid during periods
 631 Tender breasts
 633 Vaginal discharge

Skin

- 534 Dry Skin
 522 Frequent goose bumps
 524 Has Psoriasis
 527 Problems with Eczema
 531 Skin is tender

- 520 Bruises easily
 523 Has Acne
 525 Hives
 529 Skin eruptions
 532 Sores that heal slowly

- 521 Excessive perspiration
 528 Has moles which are changing in size and/or color
 526 Itchy skin
 530 Skin is rough, especially on the back of the arms
 533 Troubled with boils

Urinary

- 555 Urinates more than 2 times per night
558 Difficulty starting urination
560 Frequent urination
563 Loses bladder control
556 Bed wetting
564 Frequent bladder infections
562 Incontinence when sneezing or laughing
559 Painful urination
557 Blood in the urine
565 Frequent kidney infections
566 Kidney stones
561 Troubled by urgent urination

Men Only

- 585 Difficulty completing intercourse
588 Had a vasectomy
584 Inflammation of Testis
591 Painful genitals
593 Sores on external genitalia
586 Difficulty getting or keeping an erection
589 Had difficulty fathering children
596 Low sex drive
592 Prostate troubles
587 Discharge from the urethra
594 Herpes
590 Lumps in the testicles
595 Sexual Diseases

Surgeries

- 701 Appendix removed
716 Cataract Surgery
702 Gallbladder removed
704 Hysterectomy, complete
715 Radiated Thyroid
703 Thyroid removed
718 Bariatric/Weight loss surgery
709 Coronary Bypass
717 Hemorrhoid Surgery
705 Hysterectomy, partial
710 Spinal Surgery
700 Tonsils and/or Adenoids removed
708 Cancer surgery
711 Extremity Surgery
712 Hip Replacement
713 Knee Replacement
714 Spleen Removed (Splenectomy)
706 Tubal Ligation (fallopian tubes tied)

Medications

Please list all drugs you are currently taking on a daily basis.

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

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

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

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

<u>VITAMIN</u>	<u>BRAND</u>	<u>DOSAGE</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____