

PATIENT SYMPTOM SURVEY

Patient Name: _____

Date: _____

PLEASE CHECK YOUR PAST & PRESENT SYMPTOMS WO SE CAN BETTER EVALUATE YOUR PROBLEM

GENERAL

- | | | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen Glands |
| <input type="checkbox"/> | <input type="checkbox"/> | Hot or cold intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Weight gain |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever or chills |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |

NERVOUS SYSTEMS

- | | | |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Paralysis |
| <input type="checkbox"/> | <input type="checkbox"/> | Tremors |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness/tingling |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions |
| <input type="checkbox"/> | <input type="checkbox"/> | Imbalance |
| <input type="checkbox"/> | <input type="checkbox"/> | Memory loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle Weakness |

URINARY

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Painful urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Hard to urinate |
| <input type="checkbox"/> | <input type="checkbox"/> | Incontinence |
| <input type="checkbox"/> | <input type="checkbox"/> | Bed wetting |
| <input type="checkbox"/> | <input type="checkbox"/> | Discolored urine |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual discharge |

HEAD

- | | | |
|--------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Headache |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Entire head |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Back of head |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Forehead |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Temples |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Migraine |
| <input type="checkbox"/> | <input type="checkbox"/> | Head feels heavy |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory |
| <input type="checkbox"/> | <input type="checkbox"/> | Light-headedness |
| <input type="checkbox"/> | <input type="checkbox"/> | Fainting |
| <input type="checkbox"/> | <input type="checkbox"/> | Light bothers eyes |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of smell |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of taste |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of balance |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of hearing |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing in ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Buzzing in ears |

NECK

- | | | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain with movement |
| <input type="checkbox"/> | <input type="checkbox"/> | Pinched nerve in neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck feels out of place |
| <input type="checkbox"/> | <input type="checkbox"/> | Stiff neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle spasms in neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Grinding sounds in neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Grating sounds in neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Popping sounds in neck |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis in neck |

EMOTIONAL

- | | | |
|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety or worry |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent crying |
| <input type="checkbox"/> | <input type="checkbox"/> | Anger |
| <input type="checkbox"/> | <input type="checkbox"/> | Tension |
| <input type="checkbox"/> | <input type="checkbox"/> | Mood swings |
| <input type="checkbox"/> | <input type="checkbox"/> | Fear |
| <input type="checkbox"/> | <input type="checkbox"/> | Restlessness |
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Suicidal |
| <input type="checkbox"/> | <input type="checkbox"/> | Glasses/contacts |

REPRODUCTIVE SYSTEM

- | | | |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Painful intercourse |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Sexual problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of sex drive |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital infections |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth control method _____ |

WOMEN ONLY

- | | | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | PMS |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Date last period _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | # of pregnancies _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | # of miscarriages _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | # of abortions _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Date of last PAP _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult labor |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast problems |

LOW BACK

- | | | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Low back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Low back pain is worse when: |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Woking |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Lifting |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Stooping |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Standing |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Sitting |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Bending |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Coughing |
| <input type="checkbox"/> | <input type="checkbox"/> | Pinched nerve in low back |
| <input type="checkbox"/> | <input type="checkbox"/> | Slipped disk |
| <input type="checkbox"/> | <input type="checkbox"/> | Low back feels out of place |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle spasms |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |

MID BACK

- | | | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Mid back pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain between shoulder blades |
| <input type="checkbox"/> | <input type="checkbox"/> | Sharp stabbing pain at midback |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle spasms |

CHEST

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain around ribs |

EENT

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Earache |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Ringing in ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing loss |
| <input type="checkbox"/> | <input type="checkbox"/> | Nosebleeds |
| <input type="checkbox"/> | <input type="checkbox"/> | Hoarseness |
| <input type="checkbox"/> | <input type="checkbox"/> | Problems swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Sore throat |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw tight or sore |
| <input type="checkbox"/> | <input type="checkbox"/> | Dental problems |

NERVOUS SYSTEMS

- | | | |
|--------------------------|--------------------------|-------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Joint swelling |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Tennis elbow |
| <input type="checkbox"/> | <input type="checkbox"/> | Arm pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand sensations |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of grip |
| <input type="checkbox"/> | <input type="checkbox"/> | Midback pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Rib pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Low back problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Foot problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling foot |

SHOULDERS

- | | | |
|--------------------------|--------------------------|----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in shoulder joint |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain across shoulders |
| <input type="checkbox"/> | <input type="checkbox"/> | Bursitis (R-L) |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis (R-L) |
| <input type="checkbox"/> | <input type="checkbox"/> | Can't raise arm: |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Above shoulder level |
| <input type="checkbox"/> | <input type="checkbox"/> | ○ Over head |
| <input type="checkbox"/> | <input type="checkbox"/> | Tension in shoulders |
| <input type="checkbox"/> | <input type="checkbox"/> | Pinched nerve in shoulders |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle spasms in shoulders |

ARMS and HANDS

- | | | |
|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in upper arm |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in forearm |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in hands |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in fingers |
| <input type="checkbox"/> | <input type="checkbox"/> | Pinched nerve in arm |
| <input type="checkbox"/> | <input type="checkbox"/> | Pinched nerve in fingers |
| <input type="checkbox"/> | <input type="checkbox"/> | Pins & needles in arms |
| <input type="checkbox"/> | <input type="checkbox"/> | Pins & needles in fingers |
| <input type="checkbox"/> | <input type="checkbox"/> | Fingers go to sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Hands cold |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen joints in fingers |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis in fingers |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of grip strength |

HEART / LUNG

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Low blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough |
| <input type="checkbox"/> | <input type="checkbox"/> | Hard to breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing blood |
| <input type="checkbox"/> | <input type="checkbox"/> | Coughing phlegm |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular heartbeat |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle swelling |

GASTROINTESTINAL

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Change in appetite |
| <input type="checkbox"/> | <input type="checkbox"/> | Thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Gas |
| <input type="checkbox"/> | <input type="checkbox"/> | Hemorrhoids |
| <input type="checkbox"/> | <input type="checkbox"/> | Gall bladder |
| <input type="checkbox"/> | <input type="checkbox"/> | Belching |
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Bloody/black stools |
| <input type="checkbox"/> | <input type="checkbox"/> | Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver trouble |

SKIN

- | | | |
|--------------------------|--------------------------|-----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Easy bruising |
| <input type="checkbox"/> | <input type="checkbox"/> | Dry skin |
| <input type="checkbox"/> | <input type="checkbox"/> | Itching |
| <input type="checkbox"/> | <input type="checkbox"/> | Boils |
| <input type="checkbox"/> | <input type="checkbox"/> | Rashes |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive sweat |
| <input type="checkbox"/> | <input type="checkbox"/> | Hair changes |

HIPS, LEGS and FEET

- | | | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in buttocks (R-L) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in hip joint (R-L) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain down leg (R-L) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain down both legs |
| <input type="checkbox"/> | <input type="checkbox"/> | Leg cramps |
| <input type="checkbox"/> | <input type="checkbox"/> | Pins & needles in legs (R-L) |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness of leg (R-L) |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness of feet (R-L) |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness of toes |
| <input type="checkbox"/> | <input type="checkbox"/> | Feet feel cold |
| <input type="checkbox"/> | <input type="checkbox"/> | Cramps in feet (R-L) |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen ankles (R-L) |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen feet (R-L) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in foot (R-L) |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in knee (R-L) |

GENERAL

- | | | |
|--------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Nervousness |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritable |
| <input type="checkbox"/> | <input type="checkbox"/> | Depressed |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Generally feel rundown |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of weight |