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

	General Good Health		High Blood Pressure		Prostate Disorder
	Desires Nutritional & Metabolic Analysis		Low Blood Pressure		Hyperthyroidism
	Skin Disorder		Tachycardia (High Heart Rate)		Hypothyroidism
	Acne		Numbness		Systemic Lupus
	Psoriasis		Constipation		Infertility (female)
	Urticaria (Hives)		Indigestion		Interstitial Cystitis
	ADD/ADHD		Ulcerative Colitis		Irregular Menstrual Cycle
	Allergies, Unspecified		Depression		Menopausal Symptoms
	Allergic Rhinitis from food		Diabetes Mellitus		Hot Flashes
	Sinusitis		Diabetes Type I		Mental Disorder
	Alzheimer's		Diabetes Type II		Insomnia
	Poor Concentration/Memory		Hyperglycemia (high blood sugar)		Mouth/Throat/Tongue
	Parkinson's Disease		Hypoglycemia (low blood sugar)		Canker Sores
	Anemia		Dizziness/Balance Problem		Overweight
	Arthritic Disorder		Ear Infection		Underweight
	Osteoporosis		Epstein Barr		Sexual Disorder
	Asthma		Eye Problems		Spinal Problems
	Emphysema		Cataracts		Obesity
	Cancer		Glaucoma		GERD
	□ Breast		Macular Degeneration		HIV
	□ Prostate		Fever		Crohn's Disease
	□ Lung		Fibromyalgia		Irritable Bowel Syndrome
	□ Colon and Rectal		Gallbladder Disorder		Normal Pregnancy (only applicable If currently pregnant)
	□ Skin		Gout		Shingles
	□ Leukemia w/o remission		Headaches		Migraines
	□ Leukemia w/ remission		Hearing Loss		Rheumatoid Arthritis
	□ Lymphoma, malignant		Infertility (male)		Non-Systemic Lupus
	□ Brain Tumor, malignant		Liver Disease		Multiple Sclerosis
	Anxiety Disorder		□ Hepatitis		ALS (Lou Gehrig's)
	Autism		□ Hepatitis B		Polymyalgia Rheumatica
	Edema		□ Hepatitis C		Scleroderma
	Eczema		Kidney Disorder		Goiter
	Chronic Fatigue		Bladder Disorder		Raynaud's Syndrome
	Circulatory Disorder		Brain aneurysm		Hemochromatosis
	Heart Disease				Thalassemia
	High Cholesterol				

General Health

	Fingernail base is pink		Unexplained weight loss of over 20 lbs within the last 4 months
	Fingernail base is purple		Energy level is worse than it was 5 years ago
	Fingernails have ridges or white spots		Sleeps less than 6 hours per night
	Fingernails are soft		Unable to recall dreams the next day
	Fingernails are splitting		Sensitive to chemicals, paint, fumes, cologne
	Fingernails peel		Had blood transfusion in the past
	Pale fingernail beds		Had transplant in the past
	Blacks out easily		Takes anti-rejection drugs
	Balance problems		Had a major accident of injury
	Difficulty walking		Sleep Apnea
	Has tattoos		Toxic chemical exposure
	Brittle hair		Has been out of the country recently
	Dry hair		Had childhood vaccines
	Thin hair		Had a vaccine in the last 12 months
	Hair loss		Had a flu shot last year
	Drinks alcoholic beverages daily		Had a pneumonia vaccine last year
	Drinks less than 8 glasses of water per day		Had a Hepatitis B vaccine in the last 2 years
	Currently on Chemotherapy		Has a family history of:
	Currently on Radiation treatment		□ Cancer
	Had radiation therapy in the last year		□ Heart Disease
	Had chemotherapy in the last year		□ Diabetes
	Had chemotherapy in the past		□ Alcoholism
	Has had radiation treatments in the past		□ Depression
	Gained over 20 lbs in the last 12 months		□ Obesity
	Somewhat Overweight		
	Somewhat Underweight		

Lifestyle Habits

	Drinks beverages from a can		Drinks 1 or more pop/sodas per day		Smokes more than 1 pack per day
	Drinks alcohol		I had 4 alcoholic drinks in one day:		Rarely exercises
	Drinks caffeinated coffee		□ never		Regularly exercises
	Drinks caffeinated pop/soda		□ more than 3 months ago		Takes Vitamins
	Drinks caffeinated tea		□ less than 3 months ago		Vegetarian
	Drinks decaffeinated coffee		Has more than 5 alcoholic drinks per week		Eats no red meat
	Drinks decaffeinated pop/soda		Craves sugar / starches		Eats no meat, no dairy
	Drinks decaffeinated tea		Currently smokes		Frequent use of artificial sweeteners
	Drinks more than 3 cups of coffee per day		Quit smoking in the last 5 years		Anorexia
	Drinks more than 3 cups of tea per day		Smoked for more than 5 years		Bulimic
	Drinks diet pop/soda				

Surgeries

	Tonsillectomy and/or Adenoids		Hysterectomy, complete		Extremity surgery
	Appendix		Hysterectomy, partial		Hip replacement
	Gallbladder		Tubal ligation		Knee replacement
	Thyroid		Breast implants		Splenectomy
	Radiated thyroid		Coronary by-pass		Cataract surgery
	Cancer		Spinal surgery		Hemorroidectomy