

# PATIENT SYMPTOM SURVEY

DATE \_\_\_\_\_

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

WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ PULSE \_\_\_\_\_ O<sub>2</sub> \_\_\_\_\_

*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 1-2 times per week is notable and would be marked. Please take your time...*

## Primary Complaints

- |  |  |  |
|--|--|--|
| 090 <input type="checkbox"/> General Good Health   | 039 <input type="checkbox"/> High Blood Pressure 401.9                       | 070 <input type="checkbox"/> Hypothyroidism 244.9  |
| 091 <input type="checkbox"/> Desires Nutritional & Metabolic Analysis                      | 040 <input type="checkbox"/> Low Blood Pressure 458.9                        | 071 <input type="checkbox"/> Systemic Lupus 710.0  |
| 001 <input type="checkbox"/> Skin Disorder 692.9   | 041 <input type="checkbox"/> Tachycardia (High Heart Rate) 785.00            | 072 <input type="checkbox"/> Infertility, female 628.9   |
| 002 <input type="checkbox"/> Acne 706.1  | 042 <input type="checkbox"/> Numbness 782.0                                  | 073 <input type="checkbox"/> Interstitial Cystitis 595.1                                       |
| 003 <input type="checkbox"/> Psoriasis 696.1   | 043 <input type="checkbox"/> Constipation 564.0                              | 074 <input type="checkbox"/> Irregular Menstrual Cycle 626.4                                   |
| 004 <input type="checkbox"/> Urticaria (Hives) 708.9                                       | 044 <input type="checkbox"/> Indigestion 536.8                               | 075 <input type="checkbox"/> Menopausal Symptoms 627.2   |
| 005 <input type="checkbox"/> ADD/ADHD 314.00/314.01  | 045 <input type="checkbox"/> Ulcerative Colitis 556.9                        | 076 <input type="checkbox"/> Hot Flashes 627.2   |
| 006 <input type="checkbox"/> Allergies, Unspecified 477.9                                  | 046 <input type="checkbox"/> Depression 311                                  | 077 <input type="checkbox"/> Mental Disorder 300.9   |
| 007 <input type="checkbox"/> Allergic Rhinitis from food 477.1                             | 047 <input type="checkbox"/> Diabetes Mellitus 250.0                         | 078 <input type="checkbox"/> Insomnia 780.52   |
| 008 <input type="checkbox"/> Sinusitis 461.9   | 030 <input type="checkbox"/> Diabetes Type I 250.01                          | 079 <input type="checkbox"/> Mouth/Throat/Tongue   |
| 009 <input type="checkbox"/> Alzheimer's 331.0   | 031 <input type="checkbox"/> Diabetes Type II 250.02                         | 080 <input type="checkbox"/> Canker Sores 528.2  |
| 010 <input type="checkbox"/> Poor Concentration/ Memory 310.1                              | 029 <input type="checkbox"/> Hyperglycemia [high blood sugar] 790.29         | 081 <input type="checkbox"/> Overweight 278.02   |
| 011 <input type="checkbox"/> Parkinson's Disease 332.0                                     | 048 <input type="checkbox"/> Hypoglycemia [low blood sugar] 251.2            | 082 <input type="checkbox"/> Underweight 783.22  |
| 012 <input type="checkbox"/> Anemia 285.9  | 049 <input type="checkbox"/> Dizziness/Balance Problem 780.4                 | 083 <input type="checkbox"/> Sexual Disorder 302.89  |
| 013 <input type="checkbox"/> Arthritic Disorder 716.90                                     | 050 <input type="checkbox"/> Ear Infection 381.4                             | 084 <input type="checkbox"/> Spinal Problems 724.9   |
| 014 <input type="checkbox"/> Osteoporosis 733.00   | 051 <input type="checkbox"/> Epstein Barr 075                                | 085 <input type="checkbox"/> Obesity 278.00  |
| 015 <input type="checkbox"/> Asthma 493.90   | 052 <input type="checkbox"/> Eye Problems 379.91                             | 086 <input type="checkbox"/> GERD 530.81   |
| 016 <input type="checkbox"/> Emphysema 492.8   | 053 <input type="checkbox"/> Cataracts 366.9                                 | 087 <input type="checkbox"/> HIV 042   |
| 017 <input type="checkbox"/> Cancer  | 054 <input type="checkbox"/> Glaucoma 365.9                                  | 088 <input type="checkbox"/> Crohn's Disease 555.9   |
| 018 <input type="checkbox"/> Breast 174.9female 175.9male                                  | 055 <input type="checkbox"/> Macular Degeneration 362.50                     | 089 <input type="checkbox"/> Irritable Bowel Syndrome 564.1                                    |
| 019 <input type="checkbox"/> Prostate 185  | 056 <input type="checkbox"/> Fever 780.6                                     | 092 <input type="checkbox"/> Normal Pregnancy v22.2<br>**only applicable if currently pregnant |
| 020 <input type="checkbox"/> Lung 162.9  | 057 <input type="checkbox"/> Fibromyalgia 729.1                              | 093 <input type="checkbox"/> Shingles 053.9  |
| 021 <input type="checkbox"/> Colon and Rectal 153.9  | 058 <input type="checkbox"/> Gallbladder Disorder 575.9                      | 140 <input type="checkbox"/> Migraines 346.90  |
| 022 <input type="checkbox"/> Skin 173.9  | 059 <input type="checkbox"/> Gout 274.9                                      | 141 <input type="checkbox"/> Rheumatoid Arthritis 714.0  |
| 023 <input type="checkbox"/> Leukemia w/o remission 208.90<br>Leukemia w/ remission 208.91 | 060 <input type="checkbox"/> Headaches 784.0                                 | 142 <input type="checkbox"/> Non-Systemic Lupus 695.4  |
| 024 <input type="checkbox"/> Lymphoma, malignant 202.8                                     | 061 <input type="checkbox"/> Hearing Loss 389.9                              | 143 <input type="checkbox"/> Multiple Sclerosis 340  |
| 025 <input type="checkbox"/> Brain Tumor, malignant 191.9                                  | 062 <input type="checkbox"/> Infertility, male 606.9                         | 144 <input type="checkbox"/> ALS Lou Gerigs disease 335.20                                     |
| 026 <input type="checkbox"/> Other   | 064 <input type="checkbox"/> Liver Disease 571.9                             | 145 <input type="checkbox"/> Polymyalgia Rheumatica 725  |
| 027 <input type="checkbox"/> Anxiety Disorder 300.00                                       | 065 <input type="checkbox"/> Hepatitis 573.3                                 | 146 <input type="checkbox"/> Scleroderma 710.1   |
| 028 <input type="checkbox"/> Autism 299.00   | 066 <input type="checkbox"/> Hepatitis B 070.30                              | 171 <input type="checkbox"/> Goiter 240.9  |
| 033 <input type="checkbox"/> Edema 782.3   | 067 <input type="checkbox"/> Hepatitis C 070.51                              | 178 <input type="checkbox"/> Raynaud's Syndrome 433.8  |
| 034 <input type="checkbox"/> Eczema 692.9  | 068 <input type="checkbox"/> Kidney Disorder 593.9 or Bladder Disorder 596.9 | 179 <input type="checkbox"/> Hemochromatosis 275.0   |
| 035 <input type="checkbox"/> Chronic Fatigue 780.71  | 063 <input type="checkbox"/> Prostate Disorder 602.9                         | 180 <input type="checkbox"/> Thalassemia 282.49  |
| 036 <input type="checkbox"/> Circulatory Disorder 459.9                                    | 069 <input type="checkbox"/> Hyperthyroidism 242.90                          | 181 <input type="checkbox"/> Brain aneurysm 431  |
| 037 <input type="checkbox"/> Heart Disease 429.9   |  |  |
| 038 <input type="checkbox"/> High Cholesterol 272.0  |  |  |

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

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## General Health

- 100  Fingernail base is pink
  - 101  Fingernail base is purple
  - 102  Fingernails have ridges or white spots
  - 103  Fingernails are soft
  - 104  Fingernails are splitting
  - 105  Fingernails peel
  - 106  Pale fingernail beds
  - 107  Blacks out easily
  - 108  Balance problems
  - 109  Difficulty walking
  - 110  Has tattoos
  - 111  Brittle hair
  - 112  Dry hair
  - 113  Thin hair
  - 114  Hair loss
  - 115  Drinks alcoholic beverages daily
  - 116  Drinks less than 8 glasses of water per day
  - 117  Currently on Chemotherapy
  - 118  Currently on radiation treatment
  - 148  Had radiation therapy in the last year
  - 149  Had chemotherapy in the last year
  - 119  Had chemotherapy in the past
  - 120  Has 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  Sleeps 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
  - 138  Takes anti-rejection drugs
  - 132  Had a major accident or injury
  - 137  Sleep Apnea
  - 139  Toxic chemical exposure
  - 175  Has been out of the country recently
  - 176  Had childhood vaccines
  - 177  Had a vaccine in the last 12 months
  - 147  Had a flu shot last year
  - 182  Had a pneumonia vaccine last year
  - 183  Had a Hepatitis B vaccine in the last 2 years.
- Has a family history of:
- 184  Cancer
  - 185  Heart Disease
  - 186  Diabetes
  - 187  Alcoholism
  - 188  Depression
  - 189  Obesity

## Lifestyle Habits

- 380  Drinks beverages from a can
- 370  Drinks alcohol
- 371  Drinks caffeinated coffee
- 372  Drinks caffeinated pop/soda
- 373  Drinks caffeinated tea
- 374  Drinks decaffeinated coffee
- 375  Drinks decaffeinated pop/soda
- 376  Drinks decaffeinated tea
- 377  Drinks more than 3 cups of coffee per day
- 378  Drinks more than 3 cups of tea per day
- 388  Drinks diet pop/soda
- 379  Drinks 1 or more pop/sodas per day
- I had 4 alcoholic drinks in one day:
  - 172  never
  - 173  more than 3 months ago
  - 174  less than 3 months ago
- 381  Has more than 5 alcoholic drinks per week
- 391  Craves sugar / starches
- 382  Currently smokes
- 383  Quit smoking in the last 5 years
- 384  Smoked for more than 5 years
- 385  Smokes more than 1 pack per day
- 126  Rarely exercises
- 133  Regularly exercises
- 386  Takes Vitamins
- 134  Vegetarian
- 135  Eats no red meat
- 136  Eats no meat, no dairy
- 387  Frequent use of artificial sweeteners
- 389  Anorexia
- 390  Bulimic

## Surgeries

- |  |   |  |
|--|---|--|
| 700 <input type="checkbox"/> Tonsillectomy and/or Adenoids | 704 <input type="checkbox"/> Hysterectomy, complete | 711 <input type="checkbox"/> Extremity surgery |
| 701 <input type="checkbox"/> Appendix                      | 705 <input type="checkbox"/> Hysterectomy, partial  | 712 <input type="checkbox"/> Hip replacement   |
| 702 <input type="checkbox"/> Gallbladder                   | 706 <input type="checkbox"/> Tubal ligation         | 713 <input type="checkbox"/> Knee replacement  |
| 703 <input type="checkbox"/> Thyroid                       | 707 <input type="checkbox"/> Breast implants        | 714 <input type="checkbox"/> Splenectomy       |
| 715 <input type="checkbox"/> Radiated thyroid              | 709 <input type="checkbox"/> Coronary by-pass       | 716 <input type="checkbox"/> Cataract surgery  |
| 708 <input type="checkbox"/> Cancer                        | 710 <input type="checkbox"/> Spinal surgery         | 717 <input type="checkbox"/> Hemorrhoidectomy  |

## Gastrointestinal

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

## Respiratory

- |  |  |  |
|--|--|--|
| 485 <input type="checkbox"/> Catches severe colds    | 491 <input type="checkbox"/> Frequent colds            | 497 <input type="checkbox"/> Night sweats    |
| 486 <input type="checkbox"/> Chronic chest condition | 492 <input type="checkbox"/> Frequent nose bleeds      | 498 <input type="checkbox"/> Post nasal drip |
| 487 <input type="checkbox"/> Chronic cough           | 493 <input type="checkbox"/> Frequent sinus infections | 499 <input type="checkbox"/> Sneezing spells |
| 488 <input type="checkbox"/> Constant runny nose     | 494 <input type="checkbox"/> Frequent stuffy nose      | 500 <input type="checkbox"/> Spits up blood  |
| 489 <input type="checkbox"/> COPD                    | 495 <input type="checkbox"/> Hay fever                 | 501 <input type="checkbox"/> Spits up phlegm |
| 490 <input type="checkbox"/> Difficulty breathing    | 496 <input type="checkbox"/> Nasal polyps              | 502 <input type="checkbox"/> Wheezes         |

## Mouth and Throat

- |   |  |  |
|---|--|--|
| 400 <input type="checkbox"/> Bad breath                                     | 407 <input type="checkbox"/> Frequent fever blisters         | 414 <input type="checkbox"/> Tongue has grooves or fissures                  |
| 401 <input type="checkbox"/> Bitter taste in the mouth<br>in the morning    | 408 <input type="checkbox"/> Frequent sore throats           | 415 <input type="checkbox"/> Tongue is coated                                |
| 402 <input type="checkbox"/> Dry mouth                                      | 409 <input type="checkbox"/> Frequently has a sore<br>tongue | 416 <input type="checkbox"/> Gums bleed when brushing teeth                  |
| 403 <input type="checkbox"/> Excessive saliva                               | 410 <input type="checkbox"/> Sore gums                       | 417 <input type="checkbox"/> Toothaches                                      |
| 404 <input type="checkbox"/> Sores or cracks in the<br>corners of the mouth | 411 <input type="checkbox"/> Swollen gums                    | 418 <input type="checkbox"/> Amalgam dental fillings                         |
| 405 <input type="checkbox"/> Glands often swell                             | 412 <input type="checkbox"/> Swollen tongue                  | 420 <input type="checkbox"/> Other dental fillings<br>(gold, composite, etc) |
| 406 <input type="checkbox"/> Frequent canker sores                          | 413 <input type="checkbox"/> Tongue burns                    | 419 <input type="checkbox"/> Has had root canal(s)                           |

## Endocrine

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

## Cardiovascular

- 190  Cold feet  
191  Cold hands  
192  Experiences shortness of breath while sitting still  
193  Heart skips beats  
194  Tendency of High blood pressure  
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  
200  Pains in the heart or chest  
201  Spells of rapid heart rate  
202  Troubled with blood clots  
203  Unusually slow pulse rate  
204  Varicose veins  
205  Heart palpitations

## Skin

- 520  Bruises easily  
521  Excessive perspiration  
522  Frequent goose bumps  
523  Has acne  
524  Has Psoriasis  
525  Hives  
526  Itchy skin  
527  Problems with Eczema  
528  Has moles which are changing in size and/or color  
530  Skin is rough, especially on the back of the arms  
529  Skin eruptions  
531  Skin is tender  
532  Sores that heal slowly  
533  Troubled with boils  
534  Dry skin

## Ears

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

## Eyes

- 320  Bloodshot eyes  
321  Blurred vision  
322  Cross eyes  
323  Eye pain  
324  Eyes feel gritty  
325  Eyes watery  
326  Mild Glaucoma  
327  Far sighted  
328  Developing cataracts  
329  Mild Macular degeneration  
330  Itchy eyes  
331  Near sighted  
332  Dry Eyes

## Feet

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

## Neuromuscular

- 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  
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  
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

## Behavior Patterns

- 150  Afraid to eat anywhere except home
- 151  Always needs someone to advise
- 152  Cries often
- 153  Difficulty concentrating
- 154  Difficulty falling asleep
- 155  Difficulty staying asleep
- 156  Easily angered
- 157  Feelings are easily hurt
- 158  Frequently becomes scared for no reason
- 159  Frequently miserable or blue
- 160  Has 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

## Urinary

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

## Men Only

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

## Women Only

- 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 periods
- 619  Pre-menstrual depression
- 620  Currently taking birth control medication
- 621  Has taken birth control medication more than 1 year
- 622  Has 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
- 639  Endometriosis
- 640  Breast reduction
- 641  Breast augmentation
- 642  Abortion
- 643  D&C
- 644  Tubal pregnancy
- 645  Uterine fibroids
- 646  Ovarian fibroids
- 647  Breast fibroids
- 648  Currently Breastfeeding

## 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 past 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.

VITAMIN/HOW MUCH/BRAND