

PATIENT SYMPTOM SURVEY

DATE _____

PATIENT'S NAME _____ DOB ____/____/____

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>090 <input type="checkbox"/> General Good Health</p> <p>091 <input type="checkbox"/> Desires Nutritional & Metabolic Analysis</p> <p>001 <input type="checkbox"/> Skin Disorder 692.9</p> <p>002 <input type="checkbox"/> Acne 706.1</p> <p>003 <input type="checkbox"/> Psoriasis 696.1</p> <p>004 <input type="checkbox"/> Urticaria (Hives) 708.9</p> <p>005 <input type="checkbox"/> ADD/ADHD 314.00/314.01</p> <p>006 <input type="checkbox"/> Allergies, Unspecified 477.9</p> <p>007 <input type="checkbox"/> Allergic Rhinitis from food 477.1</p> <p>008 <input type="checkbox"/> Sinusitis 461.9</p> <p>009 <input type="checkbox"/> Alzheimer's 331.0</p> <p>010 <input type="checkbox"/> Poor Concentration/Memory 310.1</p> <p>011 <input type="checkbox"/> Parkinson's Disease 332.0</p> <p>012 <input type="checkbox"/> Anemia 285.9</p> <p>013 <input type="checkbox"/> Arthritic Disorder 716.90</p> <p>014 <input type="checkbox"/> Osteoporosis 733.00</p> <p>015 <input type="checkbox"/> Asthma 493.90</p> <p>016 <input type="checkbox"/> Emphysema 492.8</p> <p>017 <input type="checkbox"/> Cancer</p> <p style="padding-left: 20px;">018 <input type="checkbox"/> Breast 174.9female 175.9male</p> <p style="padding-left: 20px;">019 <input type="checkbox"/> Prostate 185</p> <p style="padding-left: 20px;">020 <input type="checkbox"/> Lung 162.9</p> <p style="padding-left: 20px;">021 <input type="checkbox"/> Colon and Rectal 153.9</p> <p style="padding-left: 20px;">022 <input type="checkbox"/> Skin 173.9</p> <p style="padding-left: 20px;">023 <input type="checkbox"/> Leukemia w/o remission 208.90
Leukemia w/ remission 208.91</p> <p style="padding-left: 20px;">024 <input type="checkbox"/> Lymphoma, malignant 202.8</p> <p style="padding-left: 20px;">025 <input type="checkbox"/> Brain Tumor, malignant 191.9</p> <p>027 <input type="checkbox"/> Anxiety Disorder 300.00</p> <p>028 <input type="checkbox"/> Autism 299.00</p> <p>033 <input type="checkbox"/> Edema 782.3</p> <p>034 <input type="checkbox"/> Eczema 692.9</p> <p>035 <input type="checkbox"/> Chronic Fatigue 780.71</p> <p>036 <input type="checkbox"/> Circulatory Disorder 459.9</p> <p>037 <input type="checkbox"/> Heart Disease 429.9</p> <p>038 <input type="checkbox"/> High Cholesterol 272.0</p> | <p>039 <input type="checkbox"/> High Blood Pressure 401.9</p> <p>040 <input type="checkbox"/> Low Blood Pressure 458.9</p> <p>041 <input type="checkbox"/> Tachycardia
(High Heart Rate) 785.00</p> <p>042 <input type="checkbox"/> Numbness 782.0</p> <p>043 <input type="checkbox"/> Constipation 564.0</p> <p>044 <input type="checkbox"/> Indigestion 536.8</p> <p>045 <input type="checkbox"/> Ulcerative Colitis 556.9</p> <p>046 <input type="checkbox"/> Depression 311</p> <p>047 <input type="checkbox"/> Diabetes Mellitus 250.0</p> <p>030 <input type="checkbox"/> Diabetes Type I 250.01</p> <p>031 <input type="checkbox"/> Diabetes Type II 250.02</p> <p>029 <input type="checkbox"/> Hyperglycemia
[high blood sugar] 790.29</p> <p>048 <input type="checkbox"/> Hypoglycemia
[low blood sugar] 251.2</p> <p>049 <input type="checkbox"/> Dizziness/Balance Problem
780.4</p> <p>050 <input type="checkbox"/> Ear Infection 381.4</p> <p>051 <input type="checkbox"/> Epstein Barr 075</p> <p>052 <input type="checkbox"/> Eye Problems 379.91</p> <p>053 <input type="checkbox"/> Cataracts 366.9</p> <p>054 <input type="checkbox"/> Glaucoma 365.9</p> <p>055 <input type="checkbox"/> Macular Degeneration 362.50</p> <p>056 <input type="checkbox"/> Fever 780.6</p> <p>057 <input type="checkbox"/> Fibromyalgia 729.1</p> <p>058 <input type="checkbox"/> Gallbladder Disorder 575.9</p> <p>059 <input type="checkbox"/> Gout 274.9</p> <p>060 <input type="checkbox"/> Headaches 784.0</p> <p>061 <input type="checkbox"/> Hearing Loss 389.9</p> <p>062 <input type="checkbox"/> Infertility, male 606.9</p> <p>064 <input type="checkbox"/> Liver Disease 571.9</p> <p style="padding-left: 20px;">065 <input type="checkbox"/> Hepatitis 573.3</p> <p style="padding-left: 20px;">066 <input type="checkbox"/> Hepatitis B 070.30</p> <p style="padding-left: 20px;">067 <input type="checkbox"/> Hepatitis C 070.51</p> <p>068 <input type="checkbox"/> Kidney Disorder 593.9 or
Bladder Disorder 596.9</p> | <p>063 <input type="checkbox"/> Prostate Disorder 602.9</p> <p>069 <input type="checkbox"/> Hyperthyroidism 242.90</p> <p>070 <input type="checkbox"/> Hypothyroidism 244.9</p> <p>071 <input type="checkbox"/> Systemic Lupus 710.0</p> <p>072 <input type="checkbox"/> Infertility, female 628.9</p> <p>073 <input type="checkbox"/> Interstitial Cystitis 595.1</p> <p>074 <input type="checkbox"/> Irregular Menstrual Cycle 626.4</p> <p>075 <input type="checkbox"/> Menopausal Symptoms 627.2</p> <p>076 <input type="checkbox"/> Hot Flashes 627.2</p> <p>077 <input type="checkbox"/> Mental Disorder 300.9</p> <p>078 <input type="checkbox"/> Insomnia 780.52</p> <p>079 <input type="checkbox"/> Mouth/Throat/Tongue</p> <p>080 <input type="checkbox"/> Canker Sores 528.2</p> <p>081 <input type="checkbox"/> Overweight 278.02</p> <p>082 <input type="checkbox"/> Underweight 783.22</p> <p>083 <input type="checkbox"/> Sexual Disorder 302.89</p> <p>084 <input type="checkbox"/> Spinal Problems 724.9</p> <p>085 <input type="checkbox"/> Obesity 278.00</p> <p>086 <input type="checkbox"/> GERD 530.81</p> <p>087 <input type="checkbox"/> HIV 042</p> <p>088 <input type="checkbox"/> Crohn's Disease 555.9</p> <p>089 <input type="checkbox"/> Irritable Bowel Syndrome 564.1</p> <p>092 <input type="checkbox"/> Normal Pregnancy v22.2
**only applicable if currently pregnant</p> <p>093 <input type="checkbox"/> Shingles 053.9</p> <p>140 <input type="checkbox"/> Migraines 346.90</p> <p>141 <input type="checkbox"/> Rheumatoid Arthritis 714.0</p> <p>142 <input type="checkbox"/> Non-Systemic Lupus 695.4</p> <p>143 <input type="checkbox"/> Multiple Sclerosis 340</p> <p>144 <input type="checkbox"/> ALS (Lou Gerigs) 335.20</p> <p>145 <input type="checkbox"/> Polymyalgia Rheumatica 725</p> <p>146 <input type="checkbox"/> Scleroderma 710.1</p> <p>171 <input type="checkbox"/> Goiter 240.9</p> <p>178 <input type="checkbox"/> Raynaud's Syndrome 443.8</p> <p>179 <input type="checkbox"/> Hemochromatosis 275.0</p> <p>180 <input type="checkbox"/> Thalassemia 282.49</p> <p>181 <input type="checkbox"/> Brain aneurysm 431</p> |
|--|---|--|

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

General Health

- | | |
|---|---|
| <p>100 <input type="checkbox"/> Fingernail base is pink
 101 <input type="checkbox"/> Fingernail base is purple
 102 <input type="checkbox"/> Fingernails have ridges or white spots
 103 <input type="checkbox"/> Fingernails are soft
 104 <input type="checkbox"/> Fingernails are splitting
 105 <input type="checkbox"/> Fingernails peel
 106 <input type="checkbox"/> Pale fingernail beds
 107 <input type="checkbox"/> Blacks out easily
 108 <input type="checkbox"/> Balance problems
 109 <input type="checkbox"/> Difficulty walking
 110 <input type="checkbox"/> Has tattoos
 111 <input type="checkbox"/> Brittle hair
 112 <input type="checkbox"/> Dry hair
 113 <input type="checkbox"/> Thin hair
 114 <input type="checkbox"/> Hair loss
 115 <input type="checkbox"/> Drinks alcoholic beverages daily
 116 <input type="checkbox"/> Drinks less than 8 glasses of water per day
 117 <input type="checkbox"/> Currently on Chemotherapy
 118 <input type="checkbox"/> Currently on radiation treatment
 119 <input type="checkbox"/> Had chemotherapy in the past
 120 <input type="checkbox"/> Has had radiation treatments in the past
 121 <input type="checkbox"/> Gained over 20 lbs in the last 12 months
 122 <input type="checkbox"/> Somewhat Overweight
 123 <input type="checkbox"/> Somewhat Underweight</p> | <p>124 <input type="checkbox"/> Unexplained loss of >20lbs in last 4 months
 125 <input type="checkbox"/> Energy level is worse than it was 5 years ago
 127 <input type="checkbox"/> Sleeps less than 6 hours per night
 128 <input type="checkbox"/> Unable to recall dreams the next day
 129 <input type="checkbox"/> Sensitive to chemicals, paint, fumes, cologne
 130 <input type="checkbox"/> Had blood transfusion in the past
 131 <input type="checkbox"/> Had transplant in the past
 138 <input type="checkbox"/> Takes anti-rejection drugs
 132 <input type="checkbox"/> Had a major accident or injury
 137 <input type="checkbox"/> Sleep Apnea
 139 <input type="checkbox"/> Toxic chemical exposure
 175 <input type="checkbox"/> Has been out of the country recently
 176 <input type="checkbox"/> Had childhood vaccines
 177 <input type="checkbox"/> Had a vaccine in the last 12 months
 147 <input type="checkbox"/> Had a flu shot last year
 182 <input type="checkbox"/> Had a pneumonia vaccine last year
 183 <input type="checkbox"/> Had a Hepatitis B vaccine in the last 2 years.</p> <p>Has a family history of:</p> <p>184 <input type="checkbox"/> Cancer
 185 <input type="checkbox"/> Heart Disease
 186 <input type="checkbox"/> Diabetes
 187 <input type="checkbox"/> Alcoholism
 188 <input type="checkbox"/> Depression
 189 <input type="checkbox"/> Obesity</p> |
|---|---|

Lifestyle & Environment

- Do you use? Well Water City Water Filtered? Yes No Filter Type? _____
- What kind of pipes are in your home? Steel CPVC Copper Pex Other _____
- What year was your home built? _____ Any renovations in the past year? _____
- Do you use chlorine bleach or other heavy duty cleaners in your home/work? Yes No
- Have you ever worked around heavy machinery, plumbing, automotive or the metallurgic industry? Yes No
- Explain: _____
- Have you ever worked around industrial solvents, chemicals or pesticides? Yes No
- Explain: _____

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

Surgeries

- 700 Tonsillectomy and/or Adenoids
- 701 Appendix
- 702 Gallbladder
- 703 Thyroid
- 704 Hysterectomy, complete
- 705 Hysterectomy, partial
- 706 Tubal ligation

- 707 Breast implants
- 708 Cancer
- 709 Coronary by-pass
- 710 Spinal surgery
- 711 Extremity surgery
- 712 Hip replacement
- 713 Knee replacement

- 714 Splenectomy
 - 715 Radiated thyroid
 - 716 Cataract surgery
 - 717 Hemorrhoidectomy
 - 718 Bariatric/Weight loss
- Type: _____

Gastrointestinal

- 265 4-5 bowel movements per week
- 266 3 or less 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
- 288 Eating relieves fatigue
- 289 Eats 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
- 300 Diverticulitis
- 301 Diverticulosis

Respiratory

- 485 Catches 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 Spits 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 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
529 Skin eruptions
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

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 on a daily basis.

DRUG

PRESCRIBED FOR:

HOW LONG

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

DRUG

PRESCRIBED FOR:

HOW LONG

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc.)

- | | | | |
|--------------------------------------|---------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Dairy | <input type="checkbox"/> Gluten | <input type="checkbox"/> Ragweed | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Mold | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Tree nuts |
| <input type="checkbox"/> Garlic | <input type="checkbox"/> Peanut | <input type="checkbox"/> Soy | <input type="checkbox"/> Wheat |
| <input type="checkbox"/> Other _____ | | | |

Supplements

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

VITAMIN

BRAND

DOSAGE

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____