

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. 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
**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
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...

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
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
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
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
(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 last five years 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