HEALTH STATUS SURVEY

Patient Name: _________________ File #: _____________ Date: ____________

Please circle any conditions or symptoms you are currently experiencing.
Please check (√) any conditions or symptoms which have been a problem in the past.

GENERAL SYMPTOMS
Loss of Consciousness
Blackouts
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions
Loss of Sleep
Numbness, pain or tingling
Nervousness
Weight Loss

GASTROINTESTINAL
Poor appetite
Indigestion
Excessive hunger
Belching or gas
Nausea
Vomiting (blood?)
Pain over stomach
Constipation
Diarrhea
Hemorrhoids
Jaundice
Gall bladder trouble
Intestinal worms
Ulcer
Diabetes

RESPIRATORY
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficulty breathing

CARDIOVASCULAR
Bleeding disorder
High blood pressure
Pain over heart
Stroke
Hardening of the arteries
Swollen ankles
Poor circulation
Heart or blood disease
Angina

MUSCLES AND JOINTS
Stiff neck
Back ache
Swollen Joints
Painful tailbone
Foot trouble
Shoulder pain
Arm/Forearm pain
Elbow pain
Knee Pain
Wrist or hand pain
Arthritis
Weakness or loss of strength

SKIN
Rashes, itching
Bruise easily
Dryness
Boils
Hives (allergy)

GENITO-URINARY
Trouble urinating
Blood in the urine
Kidney infection
Bed wetting
Prostate trouble

G.U. FOR WOMEN
Painful menstruation
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Vaginal discharge
Swollen breasts
Lumps in breasts

Have you ever been on birth control pills? Yes □ No □

Are you currently taking birth control pills? Yes □ No □

# of pregnancies _________

# of children _________

E.E.N.T.
Blurred vision
Failing vision
Crossed eyes
Double vision
Eye pain
Deafness
Ear ache (ringing, buzzing)
Asthma
Frequent colds
Sinus infection
Enlarged glands
Enlarged thyroid
Slurring or other speech problems
Difficulty swallowing

Have you ever had any fractures?
Yes □ No □

Have you ever been in a car accident? Yes □ No □

Have you ever been hospitalized?
Yes □ No □

If yes, why? _______________

Are you currently a smoker?
Yes □ No □

Have you ever smoked in the past? Yes □ No □

Have you ever had a positive test or diagnosis of HIV or Hepatitis A/B/C? Yes □ No □

Have you ever been diagnosed with cancer? Yes □ No □

Do you take any medications on a regular basis? Yes □ No □

If yes, please list them:

____

____

SYMPTOM DIAGRAM

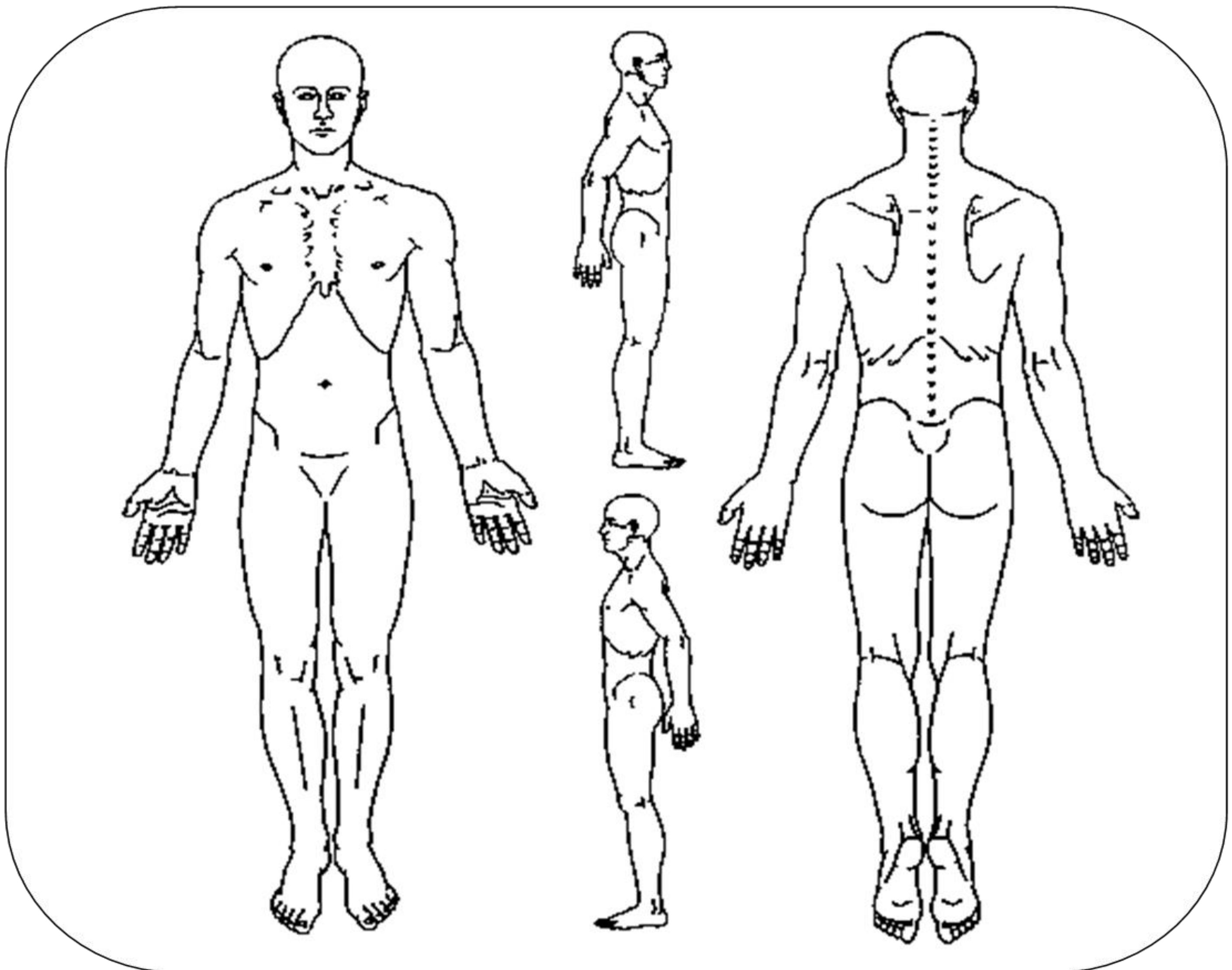
Name: ________________________ **File #:** _____________ **Date:** _______________

Please rate your pain on a scale of 0 to 10 (0 = no pain and 10 = the worst pain you've experienced).

0	1	2	3	4	5	6	7	8	9	10

In the diagram below, please **mark the areas of your body** which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include ALL areas and symptoms. Use the legend provided below to accurately describe your complaint. To complete the picture, please draw in your face.

Front Sides Back



A =ACHING & DULL **B** =BURNING **N** =NUMBNESS
P =PINS & NEEDLES **S** =STABBING & SHARP **T** =TIGHT & STIFF

Form continued on other side.