

Symptom Questionnaire

Name _____ Date _____

Please Circle All Symptoms That Apply To You

SKIN

Hives Rashes
Eczema Dermatitis
Pallor Lumps
Bruising Brittle Nails
Ridging of Nails Acne
Fungal Infection of Nails
Frequent Itching

HEAD

Headaches Migraines
Dizziness Convulsions
Sleepiness after meals
Feeling of fullness in head
Tendency of hair loss
Fainting

EYES

Dry eyes Watery eyes
Double vision Itchy eyes
Blurred vision Discharge
Glaucoma Cataracts
Date of last exam _____
Surgeries _____

EARS

Frequent aches Itchy ears
Ear drainage Hearing loss
Recurrent infections
Feeling of fullness in ear
Surgeries _____

NOSE

Runny nose Nosebleeds
Recurrent Sinusitis
Nasal stuffiness
Postnasal drip
Nasal polyps
Surgeries _____

THROAT & MOUTH

Frequent sore throats
Gagging Sore tongue
Canker sores Hoarseness
Gum disease
Voice changes
Itching roof of mouth
Extensive dental work

Respiratory

Difficulty in breathing
-lying down
Wheezing Shortness of breath
Persistent cough Sputum
Coughing up blood
Bronchial Asthma

CARDIOVASCULAR

Palpitations Irregular rhythm
Chest pain High Blood Pressure
Rapid heart beat Heart Murmur
Date/Results of last EKG

_____ Date/Results of other Cardiac Tests _____

GASTROINTESTINAL

Appetite Low Excessive
Change in weight ___+ ___- lb
Yellow jaundice Constipation
Diarrhea Rectal Bleeding
Flatulence Hemorrhoids

Bloating after meals
Rectal polyps Hepatitis _____

Abdominal cramps Colitis
Nausea/Vomiting

Vomiting blood
Difficulty Swallowing

Date of last GI series _____

Date of last colonoscopy _____

Date of last sigmoidoscopy _____

Date of last sonogram _____

Any other GI exams _____

GENITOURINARY

Urinary frequency
Inability to hold urine

Hesitancy during urination
Burning pain upon urination
Frequent night urination
Blood in urine
Frequent urinary tract infection
Repeated bladder infections
Kidney Stones Infections
Yeast infections
Syphilis /Gonorrhea /Herpes
Trichomonas
Women - vaginal discharge
Men - penile discharge
Impotence

MUSCULAR/SKELLETAL

Chronic fatigue
Muscle pains aches weakness
Joint pains aches swelling
Leg cramps when walking
Leg cramps at night
Osteoporosis
Osteoarthritis
Rheumatoid arthritis
Color change in:
Hands OR feet OR fingers
Numbness or tingling in:
Hands OR feet OR fingers

SLEEP PATTERNS

Difficulty falling asleep
Difficulty staying asleep
Frequent awakenings
Night sweats Nightmares

OTHER SYMPTOMS OR Complaints

Signature: _____