

SYMPTOM QUESTIONNAIRE

NAME: _____

DATE: _____

Please CIRCLE all CURRENT symptoms or complaints which apply to you:

SKIN

Hives
Eczema
Pallor
Bruising
Ridging of Nails
Fungal Infections of Nails
Frequent Itching

Rashes
Dermatitis
Lumps
Brittle Nails
Psoriasis
Acne

HEAD

Headaches
Dizziness
Sleepiness after meals
Feeling of fullness in head
Prone to hair loss

Migraines
Convulsions
Fainting

EYES

Dry Eyes
Double vision
Burred vision
Glaucoma
Date of last eye exam: _____
Surgeries: _____

Watery eyes
Itchy eyes
Discharge
Cataracts

EARS

Frequent earaches
Ear drainage
Frequent infections
Feeling of fullness in ears
Surgeries: _____

Itchy ears
Hearing loss

NOSE

Postnasal Drip
Chronic sinusitis
Nasal Stuffiness
Surgeries: _____

Nasal polyps
Nosebleeds
Runny nose

THROAT & MOUTH

Frequent sore throats
Sore tongue
Hoarseness

Gagging
Enlarged nodes
Canker sores

Gum disease
Itching – roof of mouth
Extensive Dental Work

Voice changes

RESPIRATORY

Difficulty in breathing
Difficulty breathing – lying down
Shortness of breath
Coughing up blood
Chronic cough
Sputum Production

Bronchial Asthma
Wheezing

CARDIOVASCULAR

Irregular rhythm
High blood pressure
Rapid heart beat
Date/result of last EKG: _____

Heart murmur
Chest pain
Palpitations

Date/result of other Cardiac tests: _____

GASTROINTESTINAL

Low appetite
Change in wt: + _____ / - _____ lbs.
Yellow jaundice
Hemorrhoids
Flatulence
Colitis
Abdominal cramps
Nausea/Vomiting
Difficulty Swallowing
Hepatitis: Type _____
Date of last GI series: _____
Date of last colonoscopy: _____
Date of last sigmoidoscopy: _____
Date of last endoscopy: _____
Date of last sonogram: _____
Any other GI exams: _____

Excessive appetite
Constipation
Rectal bleeding
Bloating after meals
Vomiting blood
Diarrhea
Rectal polyps

GENITOURINARY

Urinary frequency
Inability to hold urine
Hesitancy during urination
Burning pain upon urination
Frequent night urination
Blood in urine
Repeated urinary tract infections
Repeated bladder infections
Kidney stones / Kidney infections
Yeast infections
Syphilis / Gonorrhea / Herpes
Trichomonas
Women—Vaginal discharge
Men—Penile discharge/Impotence

MUSCULAR / SKELETAL

Chronic fatigue
Muscle aches / pains / weakness
Joint aches / pains / swelling
Leg cramps when walking
Leg cramps at night
Rheumatoid arthritis
Osteoporosis
Color change in:
Circle appropriate one
fingers OR hands OR feet
Numbness or tingling in:
Circle appropriate one
fingers OR hands OR feet

Osteoarthritis

SLEEP PATTERN

Difficulty falling asleep
Difficulty staying asleep
Frequent awakenings
Night sweats
Nightmares

ANY OTHER SYMPTOMS AND/OR CONCERNS:

