

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
Tendency to hair loss

Migraines
Convulsions
Fainting

EYES

Dry eyes
Double vision
Blurred vision
Glaucoma
Date of last eye exam: _____
Surgeries: _____

Watery eyes
Itchy eyes
Discharge
Cataracts

EARS

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

Itchy ears
Recurrent infections

NOSE

Runny Nose
Nasal Stuffiness
Postnasal drip
Surgeries: _____

Recurrent sinusitis
Nosebleeds
Nasal polyps

THROAT & MOUTH

Frequent sore throats
Sore tongue
Canker sores
Hoarseness
Voice changes

Gagging
Enlarged nodes
Hoarseness
Gum disease

Itching- roof of mouth
Extensive Dental Work

RESPIRATORY

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

Wheezing

CARDIOVASCULAR

Palpitations
Chest pain
Rapid heart beat
Date/Results of last EKG: _____
Date/Results of other Cardiac Tests: _____

Irregular rhythm
High blood pressure
Heart murmur

GASTROINTESTINAL

Low appetite
Change in weight: +____/-____ lbs
Yellow jaundice
Diarrhea
Flatulence
Bloating after meals
Colitis
Nausea/Vomiting
Difficulty swallowing
Hepatitis: Type _____
Date of last GI series: _____
Date of last colonoscopy _____
Date of last sigmoidoscopy _____
Date of last sonogram _____
Any other GI exams _____

Excessive appetite
Constipation
Rectal bleeding
Hemorrhoids
Rectal polyps
Abdominal cramps
Vomiting Blood

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
Osteoarthritis
Osteoporosis
Color change in:
Circle appropriate one
fingers OR hands OR feet
Numbness or tingling in:
Circle appropriate one
fingers OR hands OR feet

Rheumatoid arthritis

SLEEP PATTERN

Difficulty falling asleep
Difficulty staying asleep
Frequent awakenings
Night sweats
Nightmares

OTHER MAJOR SYMPTOMS AND/OR COMPLAINTS:

