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SYMPTOM QUESTIONNAIRE

Name____ Date of birth____________________________

If you currently have any of these symptoms, please check box:

CONSTITUTIONAL
- ☐ Weight gain
- ☐ Weight loss

EYES
- ☐ Glasses
- ☐ Vision loss
- ☐ Trauma

HEAD
- ☐ Dizziness
- ☐ Headache
- ☐ Ringing in ears
- ☐ Trauma
- ☐ Seizures
- ☐ Ear infections
- ☐ Hearing loss
- ☐ Runny nose
- ☐ Can't breathe out
- ☐ Nose bleeds
- ☐ Nasal polyps
- ☐ Sores in mouth
- ☐ Dentures
- ☐ Jaw clicking
- ☐ Hoarseness
- ☐ Voice changes
- ☐ Trouble swallowing
- ☐ Stiffness

SKIN
- ☐ Rash or acne
- ☐ Itching
- ☐ Bruising
- ☐ Scaling
- ☐ Hair loss
- ☐ Unusual hair growth
- ☐ Dry hair
- ☐ Oily hair
- ☐ Brittle nails
- ☐ Ridged nails

NEUROLOGIC
- ☐ Numbness and tingling
- ☐ Hypersensitive skin
- ☐ Coordination problem

CARDIOVASCULAR
- ☐ Irregular heartbeat
- ☐ Leg pain with extension
- ☐ Fluttering
- ☐ Pain with exertion
- ☐ Swelling in legs
- ☐ Fast heartbeat
- ☐ Fainting
- ☐ Varicose veins

RESPIRATORY
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Pain with breathing
- ☐ Cough
- ☐ Mucous

GUT
- ☐ Nausea
- ☐ Vomiting
- ☐ Pain with eating
- ☐ Appetite changes
- ☐ Belly pain
- ☐ Hemorrhoids
- ☐ Weight changes
- ☐ Reflux/ulcer
- ☐ Bowel problems

GENITOURINARY
- ☐ Wake up at night
- ☐ Incontinence
- ☐ Kidney/bladder infection
- ☐ Sexually active
- ☐ Sexual dissatisfaction

PSYCHIATRIC
- ☐ Depression
- ☐ Sleep problems
- ☐ Anxiety
- ☐ Other

ENDOCRINE
- ☐ Frequent voiding
- ☐ More thirsty
- ☐ Heat/cold intolerance
- ☐ Fatigue

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Muscle weakness

BREASTS
- ☐ Masses
- ☐ Discharge
- ☐ Pain

BLOOD-LYMPH
- ☐ Anemia
- ☐ Swollen lymph nodes

ALLERGIC-IMMUNOLOGIC
- ☐ Sinus allergy symptoms
- ☐ Allergic dermatitis
- ☐ Frequent illness

IMMUNIZATIONS
- ☐ Tetanus
- ☐ Pneumonia
- ☐ Shingles

INFECTIOUS DISEASE
- ☐ Chicken pox
- ☐ Scarlet/rheumatic fever
- ☐ Hepatitis
- ☐ Sexually transmitted diseases
- ☐ Tuberculosis

HABITS
- ☐ Tobacco
- ☐ Alcohol
- ☐ Coffee
- ☐ Street drugs
- ☐ Exercise

Additional comments____
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