Health Status Survey

Patient Name: _____ File #: _____ Date:_____

Please use (**X**) for any conditions or symptoms **presently** causing you problems.
Please use (**O**) the box for those conditions or symptoms that you have had in the **past**.

General Symptoms

- ☐ Loss of consciousness
- ☐ Blackouts
- ☐ Headache
- ☐ Fever
- ☐ Excess sweating
- ☐ Night sweats
- ☐ Loss of weight
- ☐ Night pain
- ☐ Generalized pain
- ☐ Nervousness
- ☐ Convulsions
- ☐ Loss of sleep

Neurologic

- ☐ Dizziness
- ☐ Fainting
- ☐ Problem speaking
- ☐ Problem swallowing
- ☐ Blurred vision
- ☐ Double vision
- ☐ Nausea
- ☐ Clumsiness
- ☐ Numbness or tingling

Muscles and Joints

- ☐ Sore/stiff neck
- ☐ Mid back ache
- ☐ Low back ache
- ☐ Painful tailbone
- ☐ Shoulder pain
- ☐ Arm/forearm pain
- ☐ Elbow pain
- ☐ Wrist/hand pain
- ☐ Hip pain
- ☐ Knee pain
- ☐ Ankle/foot trouble
- ☐ Arthritis
- ☐ Loss of strength

Eyes/Ears/Nose/Throat

- ☐ Failing vision
- ☐ Eye pain
- ☐ Failing hearing
- ☐ Earache
- ☐ Ring/buzz in ears
- ☐ Frequent colds
- ☐ Sinus infection
- ☐ Enlarged thyroid
- ☐ Enlarged glands

Respiratory

- ☐ Asthma
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood
- ☐ Difficulty breathing

Cardiovascular

- ☐ Bleeding disorder
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Stroke
- ☐ Hardening of arteries
- ☐ Varicose veins
- ☐ Swelling of ankles
- ☐ Poor circulation
- ☐ Heart/blood disease
- ☐ Angina

Genitourinary

- ☐ Trouble urinating
- ☐ Blood in urine
- ☐ Kidney infection
- ☐ Bedwetting
- ☐ Prostate trouble

GU for Women

- ☐ Painful menstruation
- ☐ Excessive flow
- ☐ Hot flashes
- ☐ Irregular/absent cycle
- ☐ Cramping/backache
- ☐ Vaginal discharge
- ☐ Swollen breasts
- ☐ Lump in breasts

Currently on birth control pills/patch?
☐ yes ☐ no
Previously on birth control pills/patch?
☐ yes ☐ no
# of pregnancies ____
# of children ____

Skin

- ☐ Rashes/itching
- ☐ Bruise easy
- ☐ Dryness
- ☐ Boils
- ☐ Hives (allergies)

Gastrointestinal

- ☐ Poor appetite
- ☐ Indigestion
- ☐ Excess hunger
- ☐ Belching or gas
- ☐ Vomiting
- ☐ Pain over stomach
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids (piles)
- ☐ Jaundice
- ☐ Gall bladder trouble
- ☐ Intestinal worms
- ☐ Ulcer
- ☐ Diabetes

Have you ever had any fractures?
☐ yes ☐ no
If yes - where?

Have you ever been in a car accident?
☐ yes ☐ no
If yes - when?

Have you ever been hospitalized?
☐ yes ☐ no
Why/When?

Are you currently a smoker?
☐ yes ☐ no How much? _____
Did you smoke previously?
☐ yes ☐ no How much? _____

Have you ever been diagnosed:
With cancer? ☐ yes ☐ no
With HIV/AIDS? ☐ yes ☐ no
With Hep A/B/C? ☐ yes ☐ no
Other……

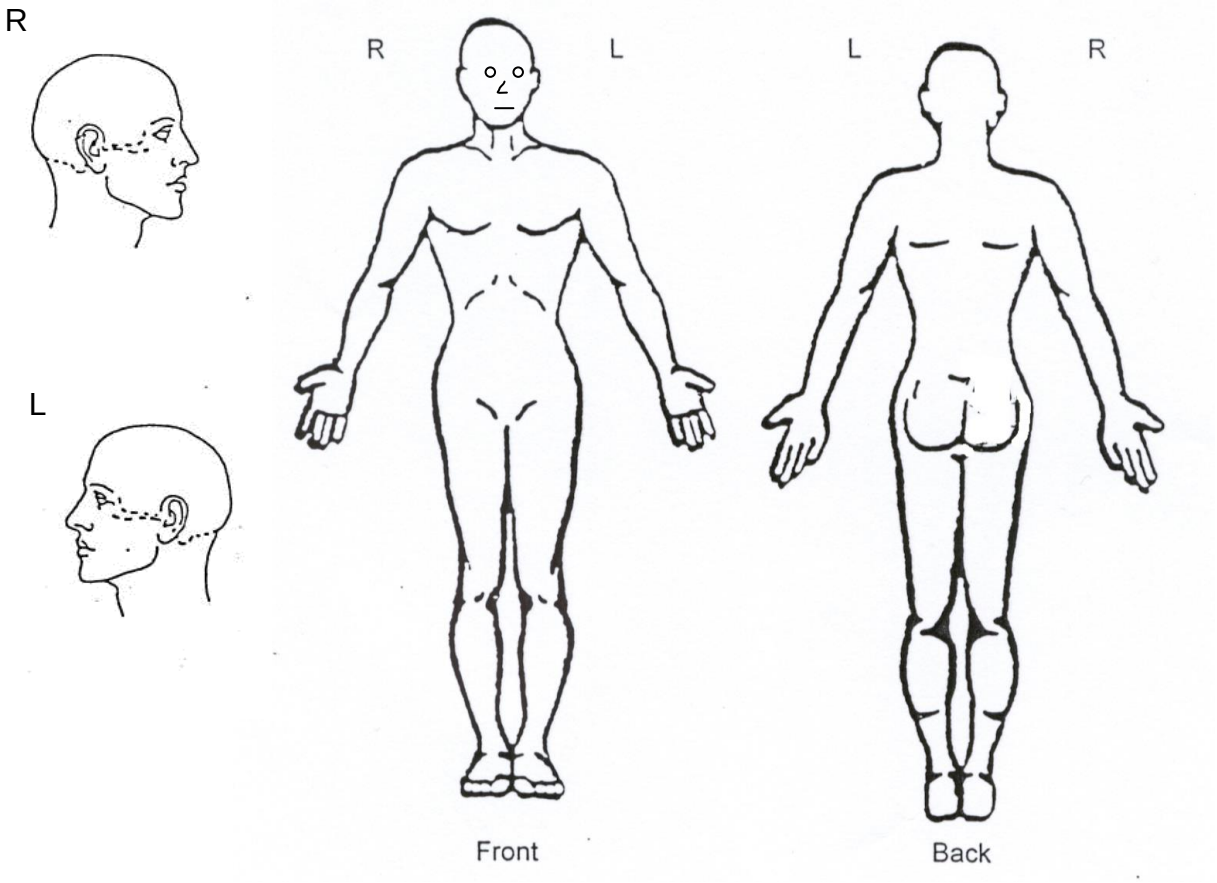
Medications (list):

Doctor's notes:

Symptoms Diagram

Patient Name: _____ File #: _____ Date:_____

In the diagrams provided below, please mark the areas on your body, which you feel best, represent the pain(s) or sensation(s) you are experiencing. Please include *all* areas. Use the symbols provided below. Please draw in the face on the diagram.

Symbols:

Numbness	≡≡≡≡≡≡≡	Pins and Needles	••••
Burning	o o o o	Stabbing & Sharp	////
Dull/Aching	Δ Δ Δ Δ Δ Δ	Stiff & Tight	x x x x