Patient Name: **Today's Date:**

Symptom Survey

Rate the following symptoms which apply to you, using the scale:
1 for mild, occasional symptoms; 2 for moderate, more frequent symptoms; 3 for sever, constant symptoms

Carbohydrate Metabolism; Allergies					
Eat when nervous		Heart palpitates if miss meal		Carve candy or coffee after noon	
Appetite excessive		Afternoon headaches		Depression	
Irritable before meals		Overdo sweets upsets stomach		Alternating constipation/diarrhea	
Get shaky if hungry		Hyperactivity		Pulse speeds after meals	
Fatigue relieved by eating		Eczema		Hives	
Migraine headaches		Hay fever		Sinus drainage	
Recurrent ear infection		Sneezing attacks			
Liver Metabolism					
Dry skin		Biliousness		Bad breath	
Itching skin / feet		Greasy food upset		Milk products distress	
Frequent skin rashes		Gallbladder problems		Burning or itching anus	
Bitter metallic taste in AM		Pain between shoulder blades			
Digestion					
Lower bowel gas >2hrs after eat		Coated tongue		Colitis	
Gas shortly after eating		Stool has foul odor		Stomach bloating after eating	
Burning sensation: better eating		Indigestion ½ to 1 hr after eat		Painful bowel movements	
How often do you have a bowel movement? _______ times per __________					
Circulation					
Hands/feet go to sleep easy		Shortness of breath on exertion		Bruise easily	
Cold hands & feet		Frequent nose bleeds		Ringing in ears	
Legs hurt after walking		Must prop up on pillows at night		Sigh frequently	
Swollen ankles, worse at night				Angina pain	
Thyroid – Pituitary – Adrenal					
Increase in weight		Abnormal thirst		Weakness, dizziness	
Decrease in appetite		Weight gain around hips/waist		Chronic fatigue	
Easily fatigued		Hair loss		Lightheaded upon standing	
Ringing in ears		Menstrual disorders		Carve salt	
Sensitive to cold		Menstrual worse since youth		Wiped out by stress	
Mentally sluggish		Sex drive lacking/reduced		Wake up tired	
Slow pulse (<65)		Nervousness		Can't gain weight	
Sleepy during day		Highly emotional		Flush easily	
Reduced initiative		Inward trembling		Heart palpitates	
Insomnia		Pulse fast at rest		Eyelids/face twitch	
Intolerance to heat		Increased appetite		Can't work under pressure	
Night sweats		Irritable & restless		Ringing in ears	
Males Only					
Prostate trouble		Difficult to get erection		Burning urination	
Bowel movement feels incomplete		Urination difficult or dribbling		Night urination frequent	
Females Only					
Depression before menses		Anxiety before menses		Water retention during menses	
Carve sugar at menses		Painful menses		Menses excessive	
Painful breasts		Breast lumps		Pain during intercourse	
Menses regular		Menses irregular		Vaginal discharge	
Vaginal itching		Use birth control pills			

Duration of period: _____ days	Frequency of periods in past 12 mos: Shortest: every _____ days Longest: every _____ days		
Number of pregnancies:	Births:	Miscarriages:	Abortions:

Type of birth control used:	How long:
Date of last Pap smear:	Age menses began:
Do you perform self-breast exams? ___ yes ___ no	If so, how often?
Date of last mammogram:	Have you had a hysterectomy? ___ yes ___ no
Have you experienced menopause? ___ yes ___ no	If so, at what age?

Thank You.