Health Status Survey

Patient Name: _____ File #: _____ Date:_____

Please X the box for any conditions or symptoms presently causing you problems.
Please check (√) 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

Medications (list):

Clinician Comments:

Symptom Diagram

Pt. 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 draw in the face on the diagram.

Symbols:

Numbness	≡≡≡≡≡≡≡	Pins and Needles	**ooooo**
Burning	**x x x x x x**	Stabbing & Sharp	~ ~ ~ ~
Dull & Aching	Δ Δ Δ Δ Δ Δ	Stiff & Tight	**2 2 2 2 2**

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