SYMPTOM QUESTIONNAIRE

Name:_____ Birth date:_____ Age:_____ Today's date:_____

Since your last comprehensive exam (yearly physical):

List any new major illnesses or surgical procedures:_____

List other physicians visited:_____

Note health changes of close relatives:_____

Instructions: Mark X in appropriate box, YES or NO

Yes	No	Do you currently use?
☐	☐	Tobacco
☐	☐	Alcohol
☐	☐	Street drugs
☐	☐	Caffeine (heavy)
☐	☐	Are you on a diet program
☐	☐	Are you on an exercise program

Yes	No	**EARS, EYES, NOSE, AND THROAT**
☐	☐	Eyesight changing
☐	☐	Annual eye exam - Dr. _____ Date_____
☐	☐	Eye pain or itching
☐	☐	Short spell of blindness
☐	☐	Hearing difficulties
☐	☐	Hearing aid
☐	☐	Buzzing in ears
☐	☐	Nasal congestion, sinus trouble
☐	☐	Hoarse voice

Yes	No	**RESPIRATORY**
☐	☐	Wheezing
☐	☐	Coughing spells
☐	☐	Shortness of breath
☐	☐	Chest colds (more than two a year)
☐	☐	Positive skin test for tuberculosis
☐	☐	TB (Tuberculosis), - Previous history

Yes	No	**CARDIOVASCULAR**
☐	☐	Racing heart or missed beats
☐	☐	Pain or tightness in chest (angina)
☐	☐	Use two or more pillows to breathe at night
☐	☐	Swollen feet or ankles
☐	☐	Leg cramps while walking

Yes	No	**ORTHOPEDIC**
☐	☐	Low back pain
☐	☐	Pain radiating down legs or ruptured disc
☐	☐	Other joint / muscle pains

Yes	No	**DIGESTIVE**
☐	☐	Difficulty swallowing
☐	☐	Heartburn - substernal pain, burning sensation
☐	☐	Change in appetite
☐	☐	Stomach pains
☐	☐	Nausea - feel like vomiting
☐	☐	Vomited blood
☐	☐	Blood or bloody stools
☐	☐	Constipation
☐	☐	Diarrhea - Loose stools

Yes	**No**	**URINARY**
☐	☐	Night Frequency - more than once
☐	☐	Day frequency - more than once every 2 hrs
☐	☐	Burning on urination
☐	☐	Delayed urine stream, or weak
☐	☐	Brown, black, or bloody urine
☐	☐	Involuntary urine loss or dribbling
☐	☐	STD's (sexually transmitted diseases)

Yes	No	**NEUROLOGICAL**
☐	☐	Frequent severe headaches - recent onset
☐	☐	Dizzy spells
☐	☐	Migraine headaches
☐	☐	Complete blackouts
☐	☐	Convulsions
☐	☐	Paralysis or numbness
☐	☐	Memory problems
☐	☐	Weak or unsteady when walking

Yes	No	**MOOD**
☐	☐	Cry often
☐	☐	Lonely or depressed
☐	☐	Worry a lot
☐	☐	Unreasonable fears / phobia

Yes	No	**GENERAL**
☐	☐	Fatigue, lack of energy
☐	☐	Fevers / Chills
☐	☐	Unexplained weight change
☐	☐	More thirsty lately
☐	☐	Sleeping difficulties
☐	☐	Recent tetanus immunization:_____
☐	☐	Skin lesions that have changed
☐	☐	Sexual dysfunction

Yes	No	**FEMALES**
		# of each:
		Pregnancies_____ Miscarriages_____
		Abortions_____ Live births_____
		Date of last menstrual period:_____
		Periods come every _____ days, lasting _____ days
☐	☐	Bleeding between periods
☐	☐	Heavy bleeding or cramping during periods
☐	☐	Pain / Bleeding with intercourse
☐	☐	Hot flashes
☐	☐	Vaginal discharge, itching or dryness
		Last PAP (date)_____
		Last mammogram (date)_____
☐	☐	Do you do self breast exams
		Birth control method_____

Physician Comments:_____

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Patient Signature_____ Date:_____ Physician initials:_____