Health Status Survey

Patient Name: ___________________ Date: __________________________

Please circle (O) any conditions or symptoms presently causing you problems.

Please check (√) those conditions or symptoms which have been a problem to you in the past.

General Symptoms
Loss of consciousness
Blackouts
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions
Loss of sleep
Numbness, pain or tingling
Nervousness
Loss of weight

Muscles and Joints
Stiff neck
Back ache
Swollen joints
Painful tail bone
Foot trouble
Shoulder pain
Arm/Forearm pain
Elbow pain
Wrist pain
Hand pain
Arthritis
Weakness or loss of strength

E.E.N.T.
Blurred vision
Failing vision (one/both eyes)
Crossed eyes
Double vision
Eye pain
Deafness
Earache
Ringing/buzzing, any noise in ears
Asthma
Frequent colds
Sinus infection
Enlarged glands
Enlarged thyroid
Slurred or other speech problems
Difficulty swallowing

Respiratory
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficulty breathing

Cardiovascular
Bleeding Disorder
High blood pressure
Pain over heart
Stroke
Hardening of arteries
Varicose veins
Swelling of ankles
Poor circulation
Heart or blood disease
Angina

Genitourinary (G.U.)
Trouble urinating
Blood in urine
Kidney infection
Bed wetting
Prostate trouble

G.U. for women
Painful menstruation
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Vaginal discharge
Swollen breasts
Lumps in breasts

Have you ever been on birth control pills? Yes No

Are you currently taking the birth control pill Yes No

# of pregnancies_______
# of children _______

Have you ever been tested for
HIV?
Hepatitis A/B/C?

Skin
Rashes, itching
Bruise easily
Dryness
Boils
Hives (allergy)

Gastrointestinal
Poor appetite
Indigestion
Excessive hunger
Belching or gas
Nausea
Vomiting (blood?)
Pain over stomach
Constipation
Diarrhea
Hemorrhoids (piles)
Jaundice
Gallbladder trouble
Intestinal worms
Ulcer
Diabetes

Have you ever had any fracture?
Yes No

Have you ever been in a car accident?
Yes No

Have you ever been hospitalized?
Yes No
If yes, why? ____________________

Are you currently a smoker?
Yes No

Have you ever smoked in the past?
Yes No

Have you ever been diagnosed with cancer?
Yes No
If yes, what kind? _________________

Do you take medication of a regular basis?

Yes No

If so, what? (blood thinner, blood pressure, etc…)
____
____

Please read and answer the following questions

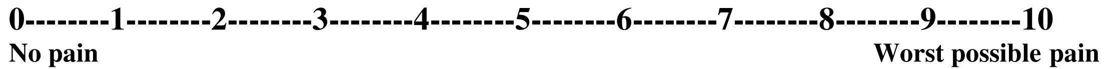
What is the reason for your visit today?____

____

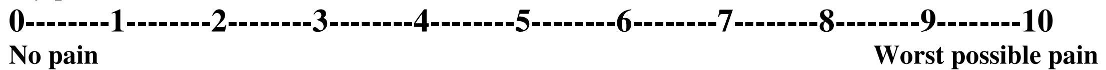
____

On the following visual analog scale, please give a numeric value to your pain:

My pain right now is…



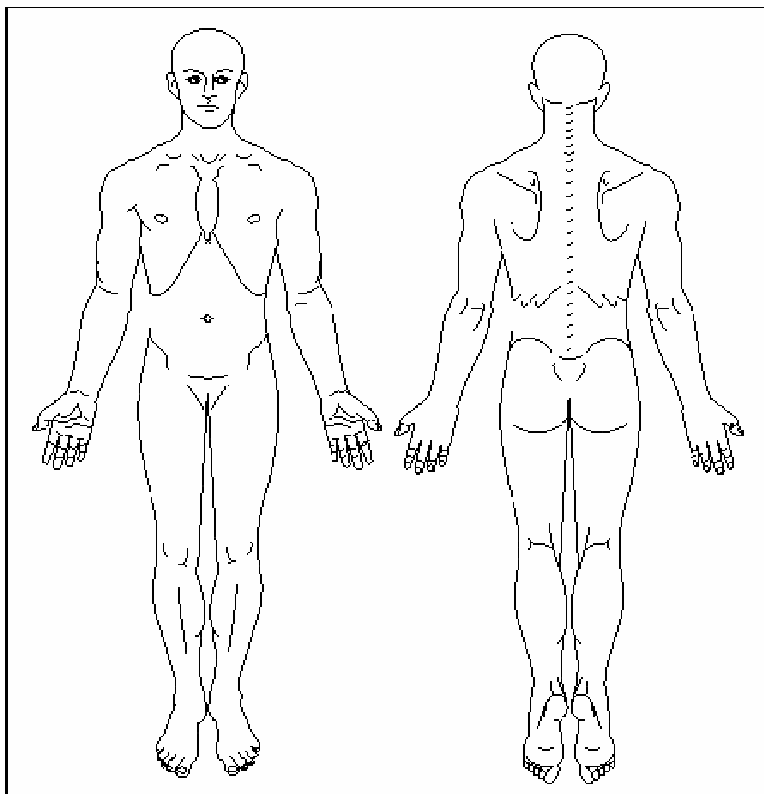
My pain at its worst is…



In the diagrams provide below, please mark the areas on your body which you feel best represent the pain or sensation(s) you are experiencing. Please include ALL areas. Use the symbols provided below. Be as accurate as possible.

Symbols:

Numbness	═══	Pins & Needles	:::::::::: ::::::::::
Burning	xxxxxx xxxxxx	Stabbing & Sharp	OOOO OOOO
Dull & Aching	++++++ ++++++	Stiff & Tight	222222 222222



Patient signature: ____________________ Date: ____________________