

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 <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Blackouts <input type="checkbox"/> Headache <input type="checkbox"/> Fever <input type="checkbox"/> Excess sweating <input type="checkbox"/> Night sweats <input type="checkbox"/> Loss of weight <input type="checkbox"/> Night pain <input type="checkbox"/> Generalized pain <input type="checkbox"/> Nervousness <input type="checkbox"/> Convulsions <input type="checkbox"/> Loss of sleep <hr/> Neurologic <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Problem speaking <input type="checkbox"/> Problem swallowing <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Nausea <input type="checkbox"/> Clumsiness <input type="checkbox"/> Numbness or tingling <hr/> Muscles and Joints <input type="checkbox"/> Sore/stiff neck <input type="checkbox"/> Mid back ache <input type="checkbox"/> Low back ache <input type="checkbox"/> Painful tailbone <input type="checkbox"/> Shoulder pain <input type="checkbox"/> Arm/forearm pain <input type="checkbox"/> Elbow pain <input type="checkbox"/> Wrist/hand pain <input type="checkbox"/> Hip pain <input type="checkbox"/> Knee pain <input type="checkbox"/> Ankle/foot trouble <input type="checkbox"/> Arthritis <input type="checkbox"/> Loss of strength <hr/> Eyes/Ears/Nose/Throat <input type="checkbox"/> Failing vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Failing hearing <input type="checkbox"/> Earache <input type="checkbox"/> Ring/buzz in ears <input type="checkbox"/> Frequent colds <input type="checkbox"/> Sinus infection <input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Enlarged glands	Respiratory <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic cough <input type="checkbox"/> Spitting up phlegm <input type="checkbox"/> Spitting up blood <input type="checkbox"/> Difficulty breathing <hr/> Cardiovascular <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> High blood pressure <input type="checkbox"/> Chest pain <input type="checkbox"/> Stroke <input type="checkbox"/> Hardening of arteries <input type="checkbox"/> Varicose veins <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Poor circulation <input type="checkbox"/> Heart/blood disease <input type="checkbox"/> Angina <hr/> Genitourinary <input type="checkbox"/> Trouble urinating <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney infection <input type="checkbox"/> Bedwetting <input type="checkbox"/> Prostate trouble <hr/> GU for Women <input type="checkbox"/> Painful menstruation <input type="checkbox"/> Excessive flow <input type="checkbox"/> Hot flashes <input type="checkbox"/> Irregular/absent cycle <input type="checkbox"/> Cramping/backache <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Swollen breasts <input type="checkbox"/> Lump in breasts <hr/> Currently on birth control pills/patch? <input type="checkbox"/> yes <input type="checkbox"/> no Previously on birth control pills/patch? <input type="checkbox"/> yes <input type="checkbox"/> no # of pregnancies _____ # of children _____	Skin <input type="checkbox"/> Rashes/itching <input type="checkbox"/> Bruise easy <input type="checkbox"/> Dryness <input type="checkbox"/> Boils <input type="checkbox"/> Hives (allergies) <hr/> Gastrointestinal <input type="checkbox"/> Poor appetite <input type="checkbox"/> Indigestion <input type="checkbox"/> Excess hunger <input type="checkbox"/> Belching or gas <input type="checkbox"/> Vomiting <input type="checkbox"/> Pain over stomach <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids (piles) <input type="checkbox"/> Jaundice <input type="checkbox"/> Gall bladder trouble <input type="checkbox"/> Intestinal worms <input type="checkbox"/> Ulcer <input type="checkbox"/> Diabetes <hr/> Have you ever had any fractures? <input type="checkbox"/> yes <input type="checkbox"/> no If yes - where? <hr/> Have you ever been in a car accident? <input type="checkbox"/> yes <input type="checkbox"/> no If yes - when? <hr/> Have you ever been hospitalized? <input type="checkbox"/> yes <input type="checkbox"/> no Why/When? <hr/> Are you currently a smoker? <input type="checkbox"/> yes <input type="checkbox"/> no How much? _____ Did you smoke previously? <input type="checkbox"/> yes <input type="checkbox"/> no How much? _____ <hr/> Have you ever been diagnosed: With cancer? <input type="checkbox"/> yes <input type="checkbox"/> no With HIV/AIDS? <input type="checkbox"/> yes <input type="checkbox"/> no With Hep A/B/C? <input type="checkbox"/> yes <input type="checkbox"/> no	
		Medications (list): <hr/> 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 ○○○○

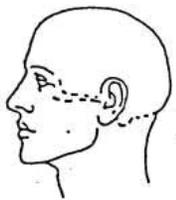
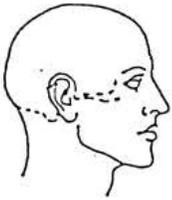
Burning x x x x x x

Stabbing & Sharp ~ ~ ~ ~

Dull & Aching Δ Δ Δ Δ Δ Δ

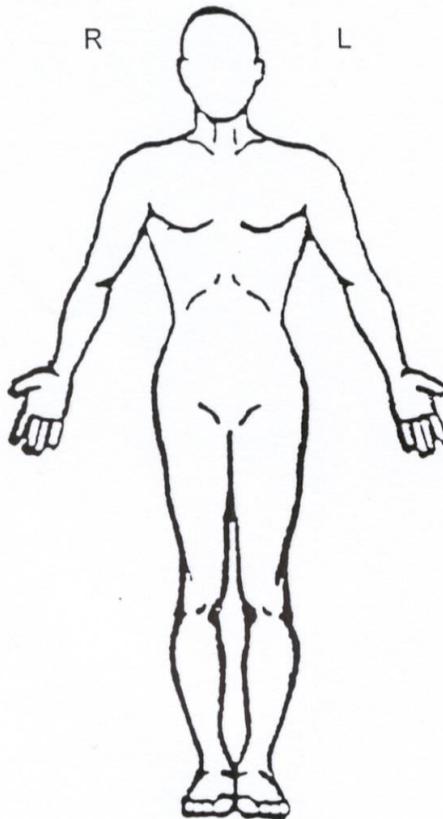
Stiff & Tight 2 2 2 2

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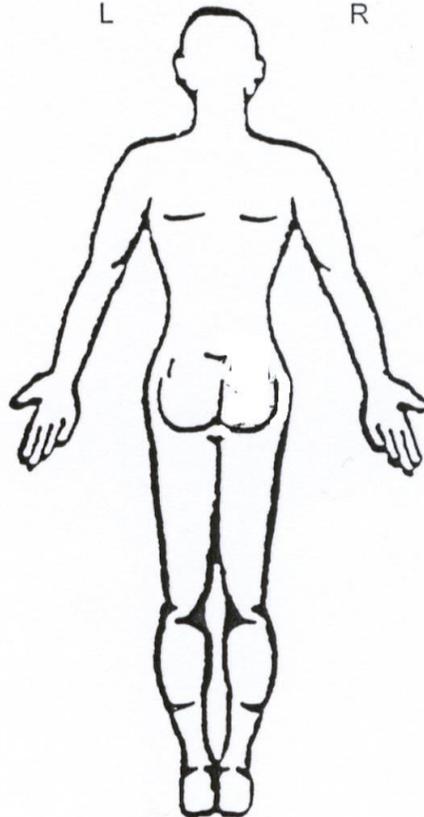
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Front

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Back