# Patient Survey Form

Do you have now or within the past year any of the following. Circle correct Response in Each Item

| Symptom | | | |
|---|---|---|---|
| Weakness/Paralysis | Never | Occasionally | Often |
| Tire Easily | Never | Occasionally | Often |
| Weight Change | Never | Occasionally | Often |
| Change in Appetite | Never | Occasionally | Often |
| Sensitivity to Hot/Cold | Never | Occasionally | Often |
| Persistent Fever | Never | Occasionally | Often |
| Night Sweats | Never | Occasionally | Often |
| Hot Flashes | Never | Occasionally | Often |
| Skin Rash | Never | Occasionally | Often |
| Skin Problems | Never | Occasionally | Often |
| Change in Nails/Hair | Never | Occasionally | Often |
| Headaches | Never | Occasionally | Often |
| Easy Bleeding | Never | Occasionally | Often |
| Easy Bruising | Never | Occasionally | Often |
| Double Vision | Never | Occasionally | Often |
| Blurred Vision | Never | Occasionally | Often |
| Eye Pain | Never | Occasionally | Often |
| Infected Eyes | Never | Occasionally | Often |
| Wear Glasses/Contacts | Never | Occasionally | Often |
| Last Eye Exam | | | |
| Ringing in Ears | Never | Occasionally | Often |
| Discharge From Ears | Never | Occasionally | Often |
| Ear Pain | Never | Occasionally | Often |
| Hearing Loss | Never | Occasionally | Often |
| Frequent Colds | Never | Occasionally | Often |
| Sinus Problems | Never | Occasionally | Often |
| Loss of Smell | Never | Occasionally | Often |
| Persistent Hoarseness | Never | Occasionally | Often |
| Sore Throat | Never | Occasionally | Often |
| Sore Tongue or Gums | Never | Occasionally | Often |
| Breast Lump/Discharge | Never | Occasionally | Often |
| Chronic Cough | Never | Occasionally | Often |
| Shortness of Breath | Never | Occasionally | Often |
| Bloody Sputum | Never | Occasionally | Often |
| Wheezing | Never | Occasionally | Often |
| Chest Pain/Discomfort | Never | Occasionally | Often |
| Purple Fingers or Lips | Never | Occasionally | Often |
| Swelling Hands | Never | Occasionally | Often |
| Swelling Feet/Ankles | Never | Occasionally | Often |
| Difficulty Breathing | Never | Occasionally | Often |
| Palpations/Flutering | Never | Occasionally | Often |
| Leg Cramps | Never | Occasionally | Often |
| Enlarged Veins | Never | Occasionally | Often |
| Difficulty Swallowing | Never | Occasionally | Often |
| Heartburn | Never | Occasionally | Often |
| Frequent Belching | Never | Occasionally | Often |
| Abdominal Cramping | Never | Occasionally | Often |

## Other Symptoms not Listed on Form:

___________________________________________

___________________________________________

___________________________________________

| Symptom | | | |
|---|---|---|---|
| Nausea/Cramping | Never | Occasionally | Often |
| Vomiting | Never | Occasionally | Often |
| Vomiting or Coughing Up | Never | Occasionally | Often |
| Chronic Diarrhea | Never | Occasionally | Often |
| Chronic Constipation | Never | Occasionally | Often |
| Rectal Bleeding | Never | Occasionally | Often |
| Black Tarry Stools | Never | Occasionally | Often |
| Dark Urine | Never | Occasionally | Often |
| Yellow Jaundice | Never | Occasionally | Often |
| Frequent Urination | Never | Occasionally | Often |
| Increased Thirst | Never | Occasionally | Often |
| Painful Urination | Never | Occasionally | Often |
| Leakage of Urine | Never | Occasionally | Often |
| Difficult Starting Urine | Never | Occasionally | Often |
| Blood in Urine | Never | Occasionally | Often |
| Lack of Sex Drive | Never | Occasionally | Often |
| Hemorrhoids | Never | Occasionally | Often |
| Backaches | Never | Occasionally | Often |
| Joint Pain/Stiffness | Never | Occasionally | Often |
| Swollen Joints | Never | Occasionally | Often |
| Muscle Cramps | Never | Occasionally | Often |
| Sleeplessness | Never | Occasionally | Often |
| Seizures | Never | Occasionally | Often |
| Depression | Never | Occasionally | Often |
| Memory Loss | Never | Occasionally | Often |
| Dizziness | Never | Occasionally | Often |
| Fainting | Never | Occasionally | Often |
| **Men Only:** | | | |
| Discharge from Penis | Never | Occasionally | Often |
| Pain/Lump in Testicles | Never | Occasionally | Often |
| Impotence | Never | Occasionally | Often |
| **Women Only** | | | |
| Age Period Began | | | |
| # of days it lasts | | | |
| Days Between Periods | | | |
| Is Your Flow Heavy | Never | Occasionally | Often |
| Spot Between Periods | Never | Occasionally | Often |
| Pain or Cramps | Never | Occasionally | Often |
| Date of Last Period | | | |
| Date Last Pelvic Exam | | | |
| Date Last Mammogram | | | |
| Any Vaginal Itching | Never | Occasionally | Often |
| Pain in Intercourse | Never | Occasionally | Often |
| Birth Control Used | | | |
| # of Pregnancies | | | |
| # Full Term Births | | | |
| # Pre Term Births | | | |

Signature ___________________________________

Physician Signature ______________________________