

Patient Survey Form

Do you have now or within the past year any of the following.

Circle correct Response in Each Item

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	<hr/>		
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/Fluttering Heart	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:

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	<hr/>		
# of days it lasts	<hr/>		
Days Between Periods	<hr/>		
Is Your Flow Heavy	Never	Occasionally	Often
Spot Between Periods	Never	Occasionally	Often
Pain or Cramps	Never	Occasionally	Often
Date of Last Period	<hr/>		
Date Last Pelvic Exam	<hr/>		
Date Last Mammogram	<hr/>		
Any Vaginal Itching	Never	Occasionally	Often
Pain in Intercourse	Never	Occasionally	Often
Birth Control Used	<hr/>		
# of Pregnancies	<hr/>		
# Full Term Births	<hr/>		
# Pre Term Births	<hr/>		

Signature _____

Physician Signature _____