

Lifestyle and Symptom Survey

Name: _____

Please check the box next to any of the following that apply to you.

Date: _____

- | | | |
|---|--|--|
| <input type="checkbox"/> Abdominal bloating or swelling | <input type="checkbox"/> Excess saliva | <input type="checkbox"/> Loss of height |
| <input type="checkbox"/> Alternating constipation and diarrhea | <input type="checkbox"/> Excessively oily skin | <input type="checkbox"/> Loss of muscle tone |
| <input type="checkbox"/> Anxious, worried, or upset during the past month | <input type="checkbox"/> Exercise less than three times a week | <input type="checkbox"/> Lower bowel gas |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Exhausted or fatigued most of the time | <input type="checkbox"/> Lowered resistance to disease or infection |
| <input type="checkbox"/> Beefy red or smooth tongue | <input type="checkbox"/> Family history of diabetes | <input type="checkbox"/> Monthly weight gain |
| <input type="checkbox"/> Belching or burping after meals | <input type="checkbox"/> Fatty foods give indigestion | <input type="checkbox"/> More thirsty than usual lately |
| <input type="checkbox"/> Black or bloody bowel movements | <input type="checkbox"/> Feel out of control | <input type="checkbox"/> Muscle spasms or cramps |
| <input type="checkbox"/> Bloating feeling after eating | <input type="checkbox"/> Feeling of undigested food in stomach after eating | <input type="checkbox"/> Need 10-12 hours of sleep per day |
| <input type="checkbox"/> Body odor | <input type="checkbox"/> Feet often painful | <input type="checkbox"/> Need to drink coffee for an energy boost |
| <input type="checkbox"/> Boils or sores that take a long time to heal | <input type="checkbox"/> Foul smelling stool or gas | <input type="checkbox"/> Nighttime leg cramps |
| <input type="checkbox"/> Bone fracture within the last year | <input type="checkbox"/> Frequent heart palpitations or fluttering | <input type="checkbox"/> Nose stuffed up or running when don't have a cold |
| <input type="checkbox"/> Bothered by coughing spells | <input type="checkbox"/> Frequent illness | <input type="checkbox"/> Pain or cramping in abdomen |
| <input type="checkbox"/> Bowel movements loose for more than a day | <input type="checkbox"/> Frequent mood swings | <input type="checkbox"/> Pain under the right side of rib cage |
| <input type="checkbox"/> Bruise easily or prolonged bleeding | <input type="checkbox"/> Frequent nosebleeds | <input type="checkbox"/> Pain with bowel movement |
| <input type="checkbox"/> Burning or gnawing stomach pain | <input type="checkbox"/> Full bladder feeling, but only pass a small amount of urine | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Catch colds or flu easily | <input type="checkbox"/> Gain weight easily and have difficulty taking it off | <input type="checkbox"/> Pains in legs when walking |
| <input type="checkbox"/> Change in size or color of a mole on skin | <input type="checkbox"/> Get sleepy when sitting | <input type="checkbox"/> Pains in stomach just before or after meals |
| <input type="checkbox"/> Chest colds more than once a month | <input type="checkbox"/> Get up at night to urinate | <input type="checkbox"/> Pains in the back or shoulder |
| <input type="checkbox"/> Chronically chapped lips | <input type="checkbox"/> Get weak and shaky if do not eat a meal on time | <input type="checkbox"/> Pains or tightness in chest |
| <input type="checkbox"/> Cloudy, red, or brownish urine | <input type="checkbox"/> Gums bleed easily upon brushing teeth | <input type="checkbox"/> Pale skin complexion |
| <input type="checkbox"/> Cold hands and feet | <input type="checkbox"/> Hair tends to get split ends or fall out | <input type="checkbox"/> Part of body always numb |
| <input type="checkbox"/> Cold sores, fever blisters | <input type="checkbox"/> Hard stools | <input type="checkbox"/> Poor memory or concentration |
| <input type="checkbox"/> Constipated more than once a month | <input type="checkbox"/> Have taken birth control pills or estrogen | <input type="checkbox"/> Poor night vision |
| <input type="checkbox"/> Consume one or more alcoholic drinks per day | <input type="checkbox"/> Headaches more than once a week | <input type="checkbox"/> Poor sense of taste or smell |
| <input type="checkbox"/> Consume two or more cups of coffee per day | <input type="checkbox"/> Headaches relieved by eating sweets or alcohol | <input type="checkbox"/> Problems with yeast or fungus |
| <input type="checkbox"/> Cough up a lot of phlegm (thick spit) | <input type="checkbox"/> Heart misses beats or has extra beats | <input type="checkbox"/> Rapid heart beat after eating sweets |
| <input type="checkbox"/> Cough up blood | <input type="checkbox"/> Heart murmur, now or in past | <input type="checkbox"/> Recurrent bladder or kidney infections |
| <input type="checkbox"/> Cracks or redness at the corners of mouth or nose | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Recurrent sore throats |
| <input type="checkbox"/> Crave salty foods | <input type="checkbox"/> Heavy menstrual periods | <input type="checkbox"/> Recurring dandruff |
| <input type="checkbox"/> Crave sweets | <input type="checkbox"/> High stress lifestyle | <input type="checkbox"/> Relief of stomach pain by drinking milk or soda pop |
| <input type="checkbox"/> Crease in earlobe | <input type="checkbox"/> History of antibiotic use | <input type="checkbox"/> Ridging on fingernails |
| <input type="checkbox"/> Currently taking diuretics (blood pressure medicine) | <input type="checkbox"/> History of ulcer, gastritis, or antacid use | <input type="checkbox"/> Ringing or other noises in ears |
| <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Indigestion 1 to 3 hours after eating | <input type="checkbox"/> Rough skin at the back of arms |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Joints swollen, red, or hot | <input type="checkbox"/> Sensitive to fumes, smoke, smog, or petrochemicals |
| <input type="checkbox"/> Difficulty either falling asleep or staying asleep | <input type="checkbox"/> Known or suspected food allergies | <input type="checkbox"/> Sensitive to hot and cold temperatures |
| <input type="checkbox"/> Difficulty in digesting certain foods | <input type="checkbox"/> Lack of ear wax or hard, dark ear wax | <input type="checkbox"/> Short and stocky body build |
| <input type="checkbox"/> Difficulty relaxing | <input type="checkbox"/> Lack of mental alertness | <input type="checkbox"/> Short of breath from little effort |
| <input type="checkbox"/> Difficulty starting urine flow | <input type="checkbox"/> Leak urine when cough or sneeze | <input type="checkbox"/> Skin blushes easily |
| <input type="checkbox"/> Dizziness or lightheadedness | <input type="checkbox"/> Less than one bowel movement per day | <input type="checkbox"/> Skin complexion problems |
| <input type="checkbox"/> Dribble after urinating | <input type="checkbox"/> Light colored stools | <input type="checkbox"/> Skin itches or burns |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Live in a city with air pollution | <input type="checkbox"/> Smoke or chew tobacco |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Live or work around smokers | <input type="checkbox"/> Sore or sensitive tongue |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Loose, floating stools | <input type="checkbox"/> Sore or swollen breasts |
| <input type="checkbox"/> Easily broken fingernails | <input type="checkbox"/> Loss of grip strength | <input type="checkbox"/> Stiff all over |
| <input type="checkbox"/> Easily irritated | | <input type="checkbox"/> Stiff in the morning |
| <input type="checkbox"/> Enlarged veins in legs | | <input type="checkbox"/> Stiff or painful muscles or joints |
| <input type="checkbox"/> Entire body achy, painful to touch | | <input type="checkbox"/> Stomach pain when emotionally upset |
| | | <input type="checkbox"/> Strong smelling urine |
| | | <input type="checkbox"/> Sweating more than usual or having |

More Questions ⇌

Lifestyle and Symptom Survey (Continued)

Name: _____

Please check the box next to any of the following that apply to you.

Date: _____

- night sweats
- Swollen bulging eyes
- Swollen feet or ankles
- Swollen lymph glands
- Tall and slender body build
- Tingling pain sensation in part of body
- Tired feeling 1 to 3 hours after eating
- Trouble remembering dreams
- Trouble waking up in the morning
- Twisting neck quickly is painful
- Unexplained swelling or lump that persists
- Urinate more than five or six times a day
- Usually feel lonely or depressed
- Wake up at night short of breath
- Water retention
- White spots on fingernails

Personal Health History

Weight: _____ pounds

Would you like to lose weight? Yes No

Check the box next to any of the following problems you have, or have had. If this is a significant problem for you please circle the condition. If known, write the year the problem began next to the item.

- AIDS
- Alcoholism
- Allergies
- Anemia
- Arthritis
- Asthma
- Bladder Trouble
- Bone or Joint Problems
- Bowel Polyps
- Bronchitis
- Bursitis
- Cancer
- Cataracts
- Cirrhosis
- Colitis
- Depression
- Diabetes
- Diverticulosis
- Eczema
- Emphysema
- Epilepsy
- Fever Blisters
- Gall Bladder Disease
- Glaucoma
- Gout
- Hay Fever
- Heart Disease
- Hemorrhoids
- Hepatitis
- Hernia
- High Blood Pressure
- Hives or Rashes
- Hot Flashes
- Hyperactive Personality
- Hypoglycemia
- Jaundice
- Kidney Trouble
- Leukemia
- Liver Disease
- Lung Disease
- Lupus (SLE)
- Migraine Headaches
- Multiple Sclerosis (MS)
- Nephritis
- Nervous Breakdown
- Neuritis or Neuralgia
- Osteoporosis
- Pancreatitis
- Pleurisy
- PMS-premenstrual syndrome
- Pneumonia
- Prostate Trouble
- Psoriasis
- Rheumatic Fever
- Rheumatism
- Sciatica
- Seborrheic Dermatitis
- Seizures
- Stomach/Duodenal Ulcer
- Stroke
- Tension/anxiety
- Thyroid Disease
- Tooth or Gum Disease
- Tuberculosis
- Unexplained Weight Loss
- Varicose Veins

Please list any other health concerns you may have: _____

Please list any drugs, either over the counter or prescription, that you are currently taking, and the frequency: _____

Surgeries – Please check the box next to any of the following surgeries you have had, or surgeries that have been recommended to you. If the surgery was actually performed, write the year it was done next to the box.

- Adrenal
- Appendix
- Back (disk)
- Bone
- Bowel
- Brain
- Breast
- Carpal Tunnel
- Cataract
- Duodenum
- Gallbladder
- Heart
- Hemorrhoids
- Hernia
- Kidney
- Liver
- Lung
- Lymph nodes
- Ovaries (or tubal ligation)
- Pancreas
- Pituitary
- Prostate
- Skin
- Spleen
- Stomach
- Testicle (or vasectomy)
- Thymus
- Thyroid
- Tonsils
- Uterus
- Other _____