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 |  | Respiratory | |  | Skin | | | | | |  |
| Loss of consciousness  Blackouts  Headache  Fever  Excess sweating  Night sweats  Loss of weight  Night pain  Generalized pain  Nervousness  Convulsions  Loss of sleep |  | Asthma  Chronic cough  Spitting up phlegm  Spitting up blood  Difficult breathing | |  | Rashes/itching  Bruise easy  Dryness  Boils  Hives (allergies) | | | | | |  |
| Cardiovascular | | Gastrointestina1 | | | | | |
| Bleeding disorder  High blood pressure  Chest pain  Stroke  Hardening of arteries  Varicose veins  Swelling of ankles  Poor circulation  Heart/blood disease  Angina | | Poor appetite  Indigestion  Excess hunger  Belching or gas  Vomiting  Pain over stomach  Constipation  Diarrhea  Hemorrhoids (piles)  Jaundice  Gall bladder trouble  Intestinal worms  Ulcer  Diabetes | | | | | |
| Neurologic |
| Dizziness  Fainting  Problem speaking  Problem swallowing  Blurred vision  Double vision  Nausea  Clun1slness  Numbness or tin fin |
| Genitourinary | |
| Trouble urinating  Blood in urine  Kidney infection  Bedwetting  Prostate trouble | |
| Muscles and Joints | Have you ever had any fractures? | | | | | | |
| Sore/stiff neck  Mid back ache  Low back ache  Painful tailbone  Shoulder pain  Arm/forearm pain  Elbow pain  Wrist/hand pain  Hip pain  Knee pain  Ankle/foot trouble  Arthritis  Loss of strength | yes | | no | | | | |
| GU for Women | | If yes – where? | | | | | | |
| Painful menstruation  Excessive flow  Hot flashes  Irregular/absent cycle  Cramping/backache  Vaginal discharge  Swollen breasts  Lump in breasts | | Have you ever been in a car accident? | | | | | | |
| yes | | no | | | | |
| If yes – where? | | | | | | |
| Have you ever been hospitalized? | | | | | | |
| yes | | no | | | | |
| Why/When? | | | | | | |
| Are you currently a smoker? | | | | | | |
| yes | no | | How much? \_\_\_\_ | | | |
| Currently on birth control pills/patch? | | | Did you smoke now? | | | | | | |
| yes | no | | yes | no | | How much? \_\_\_\_ | | | |
| Eyes/Ears/Nose/Throat | Previously on birth control pills/patch? | | | Have you ever been diagnosed? | | | | | | |
| Failing vision  Eye pain  Failing hearing  Earache  Ring/buzz in ears  Frequent colds  Sinus infection  Enlarged thyroid  Enlarged glands | yes | no | | With cancer? | | | | yes | no | |
| # of pregnancies \_\_\_\_\_ | | | With HIV/AIDS? | | | | yes | no | |
| # of children \_\_\_\_\_ | | | With HEP A/B/C? | | | | yes | no | |
| Medications (list): | | | | | | | | | |
| Clinician Comments: | | | | | | | | | |