Patient Questionaire

Name: Test Name Date: 3/2/2023 12:50:08 PM D.O.B.: 3/2/2023 12:50:08 PM
Symptom # 1 Quest Test Dates
Approx. date when this symptom first appeared: 3/2/2023 12:50:08 PM
What are the most noticeable characteristics of this symptom? p1t2
If this symptom has been diagnosed by a doctor, what was the diagnosis? p1t3
What is making the patient suffer? p1t4
How long has the patient had it? p1t5
How did this condition start? p1t6
Discuss the patient's ideas on what may have caused it. p1t6
Has the patient had this before? yes
If the patient has had it before, when and how? p1t8
How would the patient rate the relative severity of this symptom? medium
What things make this condition worse? p2t1
What things make this condition better? p2t2
Other than taking medication, what does the patient do to relieve it? p2t3
If there is pain or discomfort, describe it. p2t4
Where and when does the patient notice this symptom the most?
What does this symptom prevent the patient from doing?
What does this symptom force the patient to do?
At what hour or time of day does the patient feel this symptom the worst?
The Least?
During which season is this symptom the worst? fall
The best? fall
How do the following weather conditions affect the symptom?
- Cold no change
- Hot no change
- Wet no change
- Dry no change
- Fog no change
- Rain no change
- T-Storms no change
- Snow no change
- Sun no change
- Wind no change

How do the following indoor conditions affect the symptom?
- Warm no change
- Cool no change
- Drafty no change
- Damp no change

In which position is this symptom worst? no difference
List any foods which make the symptom worse:
List any other information about this symptom which hasn't been covered:

Select the characteristics which best fit the patient: senior female
List the patient's bodily attributes such as hair color, height, weight, etc.:
List foods and beveredges the patient dislikes:
List foods and beveredges which do not agree with the patient:
List any foods and beveredges the patient has a craving for:
List any habits of the patient wuch as smoking, drinking, alcoholism, etc.:
Which medications, internal or external, make you ill?
List the patient's prominent emotional characteristics, such as bored, outgoing, exciteable, etc.
List any emotional condition of the patient not described in the symptom section:
How would the patient rate the relative severity of this symptom? female high
List any sleep difficulties and recurring dreams or nightmares: How would the patient rate the relative severity of this symptom? female high high
If applicable, list any sexual symptoms: How would the patient rate the relative severity of this symptom? female high high high
If applicable, list any menstrual symptoms: How would the patient rate the relative severity of this symptom? female high high high high
If applicable, list physician observations and impressions: How would the patient rate the relative severity of this symptom? female high high high high high
Damp severity high
Head: severity high
Ears: severity high
Nose: severity high
Mouth: severity high
Face: severity high
Tongue: severity high

Throat: severity high
Stomach: severity high
Abdomen: severity high
Bowels: severity high
Urination: severity high
Neck: severity high
Back: severity high
Limbs: severity high