

General

- Appetite Loss
- Chills
- Dizziness
- Fainting
- Fever
- Forgetfulness
- Headaches
- Low Energy
- Nervousness
- Numbness
- Sleep Loss
- Sweats
- Weight Gain
- Weight Loss

Eyes

- Blurred Vision
- Cataracts
- Crusting/Drainage
- Excessive Dryness
- Eye Injury
- Eye Pain
- Glaucoma
- Itching
- Lack of Tears
- Loss of Vision
- Spots
- Watery Eyes

Ears-Nose-Throat

- Bleeding Gums
- Difficulty Swallowing
- Earache
- Ear Discharge
- Face Pain
- Frequent Colds
- Hay Fever
- Hearing Loss
- Hoarseness
- Loud Snoring
- Mouth Sores
- Nasal Drainage
- Nosebleeds
- Persistent Cough
- Postnasal Drip
- Ringing in Ears
- Sinus Problems
- Sleep Apnea
- Sore Throat

Heart

- Abnormal Cholesterol
- Abnormally Slow Heartbeat
- Abnormally Rapid Heartbeat
- Blackouts or Woozy Feeling
- Blood Clots in Legs
- Chest Pain
- Chest Pressure When Walking
- Congenital Heart Defect
- Fluid Retention
- Heart Attack
- Heart Disease
- Heart Murmur
- High Blood Pressure
- History of Rheumatic Fever
- Irregular Heart Beat
- Leg Pain at Rest
- Leg Pain Walking
- Low Blood Pressure
- Pacemaker
- Painful Breathing
- Pain in Legs w/ Walking
- Palpitations
- Phlebitis
- Poor Circulation
- Shortness of Breath
- Skipped Heartbeats
- Swelling of the Ankles
- Varicose Veins

Lungs / Respiratory

- Asthma
- Chronic Bronchitis
- Chronic Cough
- Cough up Sputum
- Emphysema
- Exposure to TB
- Frequent Cough
- Hoarseness
- Pneumonia
- Shortness of Breath
- Wheezing

Urinary

- Bladder Infections
- Blood in Urine
- Frequent Urination
- Hesitancy
- Kidney Infections
- Kidney Stones
- Lack of Control
- Painful Urination
- Pus Discharge
- Urination at night
- Urinary Discharge
- Wet Your Pants
- Wet the Bed

Stomach / GI

- Abdominal Pain
- Acid Reflux
- Poor Appetite
- Black or Blood Stools
- Bloating
- Bowel Changes
- Constipation
- Cramping
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gas
- Heartburn
- Hemorrhoids
- Indigestion
- Irritable Bowel Syndrome
- Jaundice
- Lack of Bowel Control
- Loose Stools
- Nausea
- Rectal Bleeding
- Regurgitation
- Stomach Pain
- Trouble Swallowing
- Unusual Stool Color
- Vomiting Blood

Skin

- Bruise Easily
- Boils
- Change in Moles
- Eczema
- Hair Problems
- Hives
- History of Cancer
- Itching
- Nail Problems
- Psoriasis
- Rash
- Scars
- Sores that won't Heal

Endocrine

- Dry Skin
- Excessive Thirst
- Excessive Hunger
- Flushing
- Hormonal Problems
- Goiter
- Neck Swelling
- Tremor
- Weight Gain

Blood

- Abnormal Blood Count
- Anemia
- Bleeding Tendency
- Blood Transfusion
- Cold Fingers and Toes
- Enlarged or Tender Glands
- Frequent Infections
- Severe Bruising

Neurological

- Balance Problems
- Dizziness
- Headaches
- Insomnia

Social / Emotional

- Anxiety
- Compulsive Behavior
- Depression
- Difficulty Concentrating
- Loss of Sexual Interest
- Panic Attacks
- Poor Sleep
- Recreational Drugs
- Short Fuse or Anger
- Suicide Ideas

Muscular/Skeletal

- Back Pain
- Buckling
- Catching
- Fractures
- Joint Swelling
- Joint Pain
- Leg Cramps
- Locking
- Neck Stiffness
- Muscle Pain
- Sciatica
- Tick Bites

Male Conditions	Female Conditions	Social
<input type="checkbox"/> Breast Lump <input type="checkbox"/> Discharge from Penis <input type="checkbox"/> Erection Difficulties <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes <input type="checkbox"/> History of STD <input type="checkbox"/> Lump in Testicles <input type="checkbox"/> Painful Testicles <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Urinary Difficulties	<input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding Between Periods <input type="checkbox"/> Breast Lump <input type="checkbox"/> Extreme Menstrual Pain <input type="checkbox"/> History of STD <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Nipple Discharge <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Date of Last Period <input type="checkbox"/> Date of Pap Smear <input type="checkbox"/> Mammogram? <input type="checkbox"/> Are You Pregnant? # of Children	<input type="checkbox"/> Hard to Concentrate <input type="checkbox"/> Feel Lonely <input type="checkbox"/> Unable to Sleep <input type="checkbox"/> Cry Frequently <input type="checkbox"/> Hopeless Outlook <input type="checkbox"/> Considered Suicide <input type="checkbox"/> Worry a lot <input type="checkbox"/> Considered Psychiatry

Please Indicate RIGHT or LEFT

1st Area of Complaint

Burning <input type="checkbox"/>	Constant <input type="checkbox"/>	Dull Ache <input type="checkbox"/>	Intermittent <input type="checkbox"/>	Numbness <input type="checkbox"/>	Sharp <input type="checkbox"/>	Stabbing <input type="checkbox"/>	
NO PAIN <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
							7 <input type="checkbox"/>
							8 <input type="checkbox"/>
							9 <input type="checkbox"/>
							10 <input type="checkbox"/>
							SEVERE

2nd Area of Complaint

Burning <input type="checkbox"/>	Constant <input type="checkbox"/>	Dull Ache <input type="checkbox"/>	Intermittent <input type="checkbox"/>	Numbness <input type="checkbox"/>	Sharp <input type="checkbox"/>	Stabbing <input type="checkbox"/>	
NO PAIN <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
							7 <input type="checkbox"/>
							8 <input type="checkbox"/>
							9 <input type="checkbox"/>
							10 <input type="checkbox"/>
							SEVERE

3rd Area of Complaint

Burning <input type="checkbox"/>	Constant <input type="checkbox"/>	Dull Ache <input type="checkbox"/>	Intermittent <input type="checkbox"/>	Numbness <input type="checkbox"/>	Sharp <input type="checkbox"/>	Stabbing <input type="checkbox"/>	
NO PAIN <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
							7 <input type="checkbox"/>
							8 <input type="checkbox"/>
							9 <input type="checkbox"/>
							10 <input type="checkbox"/>
							SEVERE

4th Area of Complaint

Burning <input type="checkbox"/>	Constant <input type="checkbox"/>	Dull Ache <input type="checkbox"/>	Intermittent <input type="checkbox"/>	Numbness <input type="checkbox"/>	Sharp <input type="checkbox"/>	Stabbing <input type="checkbox"/>	
NO PAIN <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
							7 <input type="checkbox"/>
							8 <input type="checkbox"/>
							9 <input type="checkbox"/>
							10 <input type="checkbox"/>
							SEVERE

5th Area of Complaint

Burning <input type="checkbox"/>	Constant <input type="checkbox"/>	Dull Ache <input type="checkbox"/>	Intermittent <input type="checkbox"/>	Numbness <input type="checkbox"/>	Sharp <input type="checkbox"/>	Stabbing <input type="checkbox"/>	
NO PAIN <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>
							7 <input type="checkbox"/>
							8 <input type="checkbox"/>
							9 <input type="checkbox"/>
							10 <input type="checkbox"/>
							SEVERE

In general would you say your health is:

Excellent Very Good Good Fair Poor

Compared to 1 year ago, how would you rate your health in general now?

Much better now than 1 year ago
 Somewhat better now than 1 year ago
 About the same
 Somewhat worse now than 1 year ago
 Much worse now than 1 year ago

The following items are about activities you might do in a typical day.

	Limited a lot	Limited a little	Not Limited at all
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending, kneeling or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking more than a mile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking several blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking one block	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the last 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	YES	NO
Cut down the amount of time you spend on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
Accomplish less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Were limited in the kind of work or activities	<input type="checkbox"/>	<input type="checkbox"/>
Had difficulty performing the work or other activities (for example it took extra effort)	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, have you had any of the following problems with your work or other daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	YES	NO
Cut down the amount of time you spend on work or other activities	<input type="checkbox"/>	<input type="checkbox"/>
Accomplish less than you would like	<input type="checkbox"/>	<input type="checkbox"/>
Didn't do work or other activities as carefully as usual	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, to what extent have your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

Not at all Slightly Moderately Quite a Bit Extremely

How much bodily pain have you had in the past 4 weeks?

None Very Mild Mild Moderate Severe Very Severe

During the past 4 weeks, how much did pain interfere with your normal work (Including work outside the house and housework)?

Not at all Slightly Moderately Quite a bit Extremely

These questions are about how you feel and how things have been with you during the last 4 weeks. Each question, please give 1 answer that comes closest to the way you have been feeling.

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
Did you feel full of pep?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a very nervous person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt so down in the dumps that nothing could cheer you up?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt downhearted and blue?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you feel worn out?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a happy person?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Did you feel tired?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

All of the time
 Most of the time
 Some of the time
 A little of the time
 None of the time

How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
I seem to get sick a lot easier than other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am as healthy as anybody I know	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I expect my health to get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My health is excellent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>