

HealthQuest - Patient Symptom Analysis - FEMALE

First Name: _____ Last Name: _____ Date: _____ Phone: _____

Street: _____ Suburb/Town: _____ State: _____ Postcode: _____

Date of Birth: _____ Main Reason for Visit: _____

Scoring Circle the score in the column that best suits your symptoms, in either Severity or Frequency.

Severity Frequency
 Column **A** = Never
 Column **B** = Mild ——— or - Infrequent Symptoms (twice per week or less)
 Column **C** = Moderate — or - Frequent Symptoms (3 to 6 times a weekly)
 Column **D** = Severe ——— or - Daily Symptoms

Note: Circle the zeros as well as number

Operations: _____

Section 1.	A	B	C	D
1. Curved spine, height loss, stooped base of neck hump (dowager's hump)	0	2	5	10
2. Bone pain, back, hip or knee pain	0	2	5	10
3. Spinal problems, pain, Sciatic pain	0	2	5	10
4. Osteoporosis	0	2	5	10
5. Recent broken bones, fractures	0	2	5	10
6. Arthritis - Osteo/Rheumatoid	0	2	5	10
7. Joints swelling painful, deformity, injury, stiffness	0	2	5	10
8. Noisy joints (creak, grind etc.)	0	1	3	5
9. Nodules on fingers	0	2	5	10
10. High uric acid level	0	2	5	10
11. Damaged disc, slipped disc	0	2	5	10
12. Bursitis or tendonitis	0	1	3	5
1. Total				
Section 2.				
1. Tightness or pain in back, neck or shoulder muscles	0	2	5	10
2. Muscular spasms, cramping	0	2	5	10
4. Stiffness in muscles	0	2	5	10
5. Tenderness, pain in muscles	0	2	5	10
6. Weakness in muscles	0	2	5	10
7. Trembling (fasciculation)	0	2	5	10
2. Total				
Section 3.				
1. Chest tightness on stress or exertion	0	2	5	10
2. Palpitations, arrhythmias, extra beats	0	2	5	10
3. Swelling of the ankles	0	2	5	7
4. Shortness of breath on exertion/rest	0	1	3	5
5. Calf pain on exercise	0	2	5	7
6. Dizziness on exertion	0	2	5	7
7. Previous angina attacks, heart attack or stroke	No		Yes	(10)

Section 3 continued ...	A	B	C	D
8. Known cardiac murmur or condition	No		Yes	(10)
9. High blood cholesterol, triglycerides or blood clotting problems	No		Yes	(10)
10. Blood Pressure or Heart medication	No		Yes	(15)
3. Total				
Section 4.				
1. Blue, numb, cold fingers or toes	No		Yes	(10)
2. Ulcers, sores on legs and feet	No		Yes	(10)
3. Shiny, discoloured, hairless skin on arms or legs / Varicose veins	No		Yes	(10)
4. Cramps, pain in legs when walking	0	2	5	10
5. Pins and needles, numbness - hands, feet	0	1	3	5
6. Fluid retention feet, legs, body	0	2	5	10
7. Difficulty with written or spoken words or concentration	0	1	3	5
8. Dizziness, ringing in the ears	0	1	3	5
9. Fleeting nausea / Hearing loss	0	1	3	5
10. Previous deep vein thrombosis	0	2	5	10
11. Take Anti-clotting medication	No		Yes	(18)
4. Total				
Section 5.				
1. Morning headaches	0	1	2	3
2. Feel tired, nervy, weak	0	1	2	3
3. Ringing in ears / Sleepy, dizzy	0	1	2	3
4. Hi Blood Pressure / Heart medication	No		Yes	(15)
5. Flushing with no known cause	0	1	2	3
6. Tingling and numb hands and feet	0	1	2	3
7. Blurry vision	0	1	2	3
5. Total				

Section 6.	A	B	C	D
1. Smoker	No		Yes	(10)
2. Cough	0	2	5	10
3. Asthma, Wheezing	0	2	5	10
4. Repeated chest infections	0	2	5	10
5. Shortness of breath on effort or at rest	0	2	5	7
6. Chest pain on breathing or coughing	0	2	5	10
7. Gets chest infections easily	0	2	5	10
8. Coughing up mucus/phlegm	0	2	5	10
9. Takes asthma medication	No		Yes	(10)

6. Total

Section 7.

1. Burping up gas	0	2	5	10
2. Bloating after meals	0	2	5	10
3. Abdominal distention, swelling	0	1	3	5
4. Less than 1 bowel movement per day	0	1	2	3
5. Food intolerances, allergies	0	1	2	3
6. Foul smelling breath	0	1	3	5
7. Low vitamin B12 levels	No		Yes	(10)
8. Acne or Acne Rosacea	0	2	5	8
9. Eczema	0	1	3	5
10. Flaking, peeling or brittle nails	0	1	3	5

7. Total

Section 8.

1. Past duodenal ulcers, stomach problems	No		Yes	(8)
2. Do you have an ulcer now ?	No		Yes	(10)
3. Do you use antacids ?	No		Yes	(8)
4. Stomach pains on lying down or bending after a meal	0	1	3	5
5. Stomach symptoms, heartburn, pain	0	2	5	8
6. Food, drink makes stomach feel better	0	2	5	8
7. Black stools (blood)	0	2	5	10
8. Helicobacter breath test positive	No		Yes	(10)

8. Total

Section 9.

1. Abdominal cramps after eating meals	0	1	2	3
2. Abdominal cramps opening bowels	0	1	2	3
3. Loose stools, constipation	0	2	5	10
4. Tiredness after meals	0	1	3	5
5. Smelly stools	0	2	5	7
6. Acne, Food allergies	0	2	5	7
7. Inflammation of the small bowel	0	2	5	7
8. Mucous in stools	0	2	5	7
9. Fullness, indigestion for 2-4 hrs after meals	0	1	3	5
10. Bowel gas, flatulence, wind	0	1	3	5

9. Total

Section 10.

1. Chronic fungal infections, thrush, parasites abnormal bacteria	0	1	3	5
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<i>Section 10 cont...</i>	A	B	C	D
2. Low fibre diet	0	1	3	5
3. Constipation, diarrhoea, colitis	0	2	5	10
4. Antibiotic use (note frequency)	0	2	5	10
5. High meat intake	0	1	3	5
6. Abdominal bloating / distention	0	2	5	7
7. Bowel gas, flatulence, wind	0	2	5	7
8. Abdominal pain, Diverticulitis	0	1	3	5
9. Changeable bowel habits	0	2	5	7
10. Red blood in stool (or blood found in stool on testing)	0	2	5	10

10. Total

Section 11.

1. Indigestion, pain or nausea after eating or nausea after drinking alcohol	0	2	5	10
2. Previous hepatitis or abnormal liver function tests	No		Yes	(10)
3. Pain under front right side of rib cage, right side of back	0	2	5	8
4. Yellowness of sclera (whites of eyes)	0	2	5	10
5. Indigestion or pains after fatty food	0	1	3	5
6. Light coloured stools, dark urine	0	1	3	5
7. High cholesterol or triglycerides	0	1	3	5
8. Gallstones, pain under right hand side of rib cage	0	1	2	3
9. Fatigue, tired all the time	0	1	2	3
10. Irritability, depression, foggy thinking	0	1	2	3
11. Reddened palms or skin	0	1	3	5
12. Generally feels unwell	0	1	3	5

11. Total

Section 12.

1. Poor sense of smell and taste	0	1	2	3
2. Dark under the eyes, on cheeks	0	1	2	3
3. Catch colds and flu easily	No		Yes	(10)
4. Nasal blockage, mucus, post nasal drip, sore throat	0	2	5	7
5. Frequent antibiotic use	0	2	5	7
6. Cold sores, herpes, HPV, HIV	No		Yes	(10)
7. Ear, nose, throat, eyes, lung, skin infections	0	2	5	10
8. Discharge from ears	0	2	5	10
9. Slow healing wounds	0	2	5	10
10. Swelling in groin, armpits, neck	0	2	5	10

12. Total

Section 13.

1. Hayfever, sinusitis	0	2	5	10
2. Eczema, psoriasis, dermatitis	No		Yes	(10)
3. Urticaria (hives)	No		Yes	(10)
4. Arthritis (osteo, rheumatoid)	0	1	3	5
5. Headaches & Migraine	0	2	5	10
6. Itching or red eyes	0	2	5	10
7. Mouth ulcers	0	2	5	10