**Symptom Survey - Dr. Cola’s Clinic**

[DrColasClinic.com](http://www.drcolasclinic.com)|email: drcola1010@gmail.com | call: 208.315.1010 | fax: 208.634.1010

**Enter 1 for mild symptoms (occur once or twice a year).**

**Enter 2 for moderate symptoms (occur several times a year).**

**Enter 3 for severe symptoms (you are aware of it almost constantly).**

**Enter P for symptoms experienced in the past.**

**Leave blank if not applicable.**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_**

**Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### Category 1

1. \_\_\_\_ Acid foods upset
2. \_\_\_\_ Get chilled often
3. \_\_\_\_ “Lump” in throat
4. \_\_\_\_ Dry mouth-eyes-nose
5. \_\_\_\_ Pulse speeds after meals
6. \_\_\_\_ Keyed up; fail to calm
7. \_\_\_\_ Cuts heal slowly
8. \_\_\_\_ Gag easily
9. \_\_\_\_ Unable to relax
10. \_\_\_\_ Extremities cold clammy
11. \_\_\_\_ Strong light irritates
12. \_\_\_\_ Urine amounts reduced
13. \_\_\_\_ Heart pounds after eating
14. \_\_\_\_ Nervous stomach
15. \_\_\_\_ Appetite reduced
16. \_\_\_\_ Cold sweats often
17. \_\_\_\_ Fever easily raised
18. \_\_\_\_ Neuralgia-like pains
19. \_\_\_\_ Staring, blinks little
20. \_\_\_\_ Sour stomach frequent
21. \_\_\_\_ Joint stiffness after arising
22. \_\_\_\_ Muscle leg toe cramps at night
23. \_\_\_\_ “Butterflies” in stomach
24. \_\_\_\_ Eyes or nose watery
25. \_\_\_\_ Eyes Blink Often
26. \_\_\_\_ Eyelids Swollen
27. \_\_\_\_ Indigestion soon after meals
28. \_\_\_\_ Always feels hungry. Lightheaded Often
29. \_\_\_\_ Digestion Rapid
30. \_\_\_\_ Vomiting frequent
31. \_\_\_\_ Hoarseness frequent
32. \_\_\_\_ Breathing Irregular
33. \_\_\_\_ Pulse Slow. Feels irregular
34. \_\_\_\_ Gagging reflex slow
35. \_\_\_\_ Difficulty Swallowing
36. \_\_\_\_ Constipation/ Diarrhea alternating
37. \_\_\_\_ “Slow Starter”
38. \_\_\_\_ Get Chilled frequently
39. \_\_\_\_ Perspire easily
40. \_\_\_\_ Circulation Poor, sensitive to cold
41. \_\_\_\_ Subject to colds, asthma bronchitis

### Category 2

1. \_\_\_\_ Eat when nervous
2. \_\_\_\_ Excessive appetite
3. \_\_\_\_ Hungry between meals
4. \_\_\_\_ Irritable between meals
5. \_\_\_\_ Get shaky if hungry
6. \_\_\_\_ Fatigue, eating relieves
7. \_\_\_\_ Lightheadedness if meals delayed
8. \_\_\_\_ Heart palpitates if meals missed or delayed
9. \_\_\_\_ Afternoon headaches
10. \_\_\_\_ Overeating sweets upsets
11. \_\_\_\_ Awaken after few hours of sleep; hard to get

back asleep

1. \_\_\_\_ Crave candy or coffee in afternoon
2. \_\_\_\_ Moods of depression, blues or melancholy
3. \_\_\_\_ Abnormal craving for sweets or snacks

### Category 3

1. \_\_\_\_ Hands and feet go to sleep easily
2. \_\_\_\_ Sigh frequently “air hunger”
3. \_\_\_\_ Aware of breathing heavily
4. \_\_\_\_ High altitude discomfort
5. \_\_\_\_ Opens window in closed room
6. \_\_\_\_ Susceptible to colds and fever
7. \_\_\_\_ Afternoon yawner
8. \_\_\_\_ Get drowsy often
9. \_\_\_\_ Swollen ankles worse at night
10. \_\_\_\_ Muscle cramps worse with exercise. Charley Horse
11. \_\_\_\_ Shortness of breath with exertion
12. \_\_\_\_ Dull pain in chest or radiating into left arm. Worse with exertion
13. \_\_\_\_ Bruise easily. Black/Blue spots
14. \_\_\_\_ Tendency to anemia.
15. \_\_\_\_ Nose bleeds frequently
16. \_\_\_\_ Ringing in ear
17. \_\_\_\_ Tension or tightness under breast bone

### Category 4

1. \_\_\_\_ Dizziness
2. \_\_\_\_ Dry Skin
3. \_\_\_\_ Burning Feet
4. \_\_\_\_ Blurred Vision
5. \_\_\_\_ Itching skin and feet.
6. \_\_\_\_ Excessive hair loss
7. \_\_\_\_ Frequent skin rashes
8. \_\_\_\_ Bitter metallic taste in mouth in morning
9. \_\_\_\_ Bowel movements painful or difficult
10. \_\_\_\_ A worrier, feels insecure
11. \_\_\_\_ Feeling queasy, headache over eyes
12. \_\_\_\_ Greasy foods upset
13. \_\_\_\_ Stools light-colored
14. \_\_\_\_ Skin peels on foot soles
15. \_\_\_\_ Pain between shoulder blades
16. \_\_\_\_ Use laxatives
17. \_\_\_\_ Stools alternate between soft to watery
18. \_\_\_\_ History of gallbladder attacks or gallstones
19. \_\_\_\_ Sneezing attacks
20. \_\_\_\_ Dreaming, nightmares; don't remember dreams
21. \_\_\_\_ Bad Breath (halitosis)
22. \_\_\_\_ Milk products cause distress
23. \_\_\_\_ Sensitive to hot water
24. \_\_\_\_ Burning or itching anus
25. \_\_\_\_ Craves sweets

### Category 5

1. \_\_\_\_ Loss of taste for meat
2. \_\_\_\_ Lower bowel gas several hour after eating
3. \_\_\_\_ Burning stomach sensation--eating relieves
4. \_\_\_\_ Tongue – white coating
5. \_\_\_\_ Large amounts of foul smelling gas
6. \_\_\_\_ Indigestion after meals
7. \_\_\_\_ Mucus on stools
8. \_\_\_\_ Gas shortly after eating
9. \_\_\_\_ Stomach bloating after meals

### Category 6

1. \_\_\_\_ Insomnia
2. \_\_\_\_ Nervousness
3. \_\_\_\_ Can't gain weight
4. \_\_\_\_ Intolerance to heat
5. \_\_\_\_ Highly emotional
6. \_\_\_\_ Flush easily
7. \_\_\_\_ Night Sweats
8. \_\_\_\_ Thin moist skin
9. \_\_\_\_ Inward Trembling
10. \_\_\_\_ Heart Palpitates
11. \_\_\_\_ Increased appetite without weight gain
12. \_\_\_\_ Pulse fast at rest
13. \_\_\_\_ Eyelids and face twitch
14. \_\_\_\_ Irritable and restless
15. \_\_\_\_ Can't work under pressure
16. \_\_\_\_ Increase in weight
17. \_\_\_\_ Decrease in appetite
18. \_\_\_\_ Fatigue easily
19. \_\_\_\_ Ringing in Ear
20. \_\_\_\_ Sleeping during day
21. \_\_\_\_ Sensitive to cold
22. \_\_\_\_ Dry or Scaly skin
23. \_\_\_\_ Constipation
24. \_\_\_\_ Mental Sluggishness
25. \_\_\_\_ Hair Coarse
26. \_\_\_\_ Headache upon rising, wears off during day
27. \_\_\_\_ Slow Pulse below 65
28. \_\_\_\_ Frequency
29. \_\_\_\_ Impaired hearing
30. \_\_\_\_ Reduced initiative

### Category 7

1. \_\_\_\_ Failing memory
2. \_\_\_\_ Low blood pressure
3. \_\_\_\_ Increased sex drive
4. \_\_\_\_ Headache - splitting type
5. \_\_\_\_ Decreased sugar tolerance
6. \_\_\_\_ Abnormal thirst
7. \_\_\_\_ Bloating of abdomen
8. \_\_\_\_ Weight gain around hips or waist
9. \_\_\_\_ Sex drive reduced or lacking
10. \_\_\_\_ Tendency to ulcers, colitis
11. \_\_\_\_ Increased sugar tolerance (can eat a lot of sugar)
12. \_\_\_\_ Menstrual disorders
13. \_\_\_\_ Teenagers lack of menstrual function

### Category 8

1. \_\_\_\_ Dizziness
2. \_\_\_\_ Headache
3. \_\_\_\_ Hot Flashes
4. \_\_\_\_ Increased blood pressure
5. \_\_\_\_ Hair growth on face or body (female)
6. \_\_\_\_ Sugar in urine (not diabetes)
7. \_\_\_\_ Masculine tendency (female)

### Category 9

1. \_\_\_\_ Weakness, Dizziness upon rising
2. \_\_\_\_ Fatigue
3. \_\_\_\_ Low blood pressure
4. \_\_\_\_ Nail weak or ridged
5. \_\_\_\_ Tendency to hives
6. \_\_\_\_ Arthritic Tendency
7. \_\_\_\_ Perspiration increase
8. \_\_\_\_ Bowel Disorder
9. \_\_\_\_ Poor Circulation
10. \_\_\_\_ Swollen Ankles
11. \_\_\_\_ Crave Salt
12. \_\_\_\_ Brown spots or bronzing of skin
13. \_\_\_\_ Allergies, tendency to asthma
14. \_\_\_\_ Weakness after colds, influenza
15. \_\_\_\_ Exhaustion, muscular or nervous
16. \_\_\_\_ Respiratory disorder

### Category 10

1. \_\_\_\_ Very easily fatigued
2. \_\_\_\_ PMS
3. \_\_\_\_ Painful menses
4. \_\_\_\_ Depression PMS
5. \_\_\_\_ Excessive menses, prolonged
6. \_\_\_\_ Painful breast
7. \_\_\_\_ Menstruate too frequently
8. \_\_\_\_ Vaginal discharge
9. \_\_\_\_ Hysterectomy / ovaries removed
10. \_\_\_\_ Menopausal hot flashes
11. \_\_\_\_ Menses scanty or missed
12. \_\_\_\_ Acne worse at menses
13. \_\_\_\_ Depression long standing

### Category 11

1. \_\_\_\_ Prostate trouble
2. \_\_\_\_ Urination difficult or dribbling
3. \_\_\_\_ Night urination frequent
4. \_\_\_\_ Depression
5. \_\_\_\_ Pain on inside of legs or heels
6. \_\_\_\_ Feeling of incomplete bowel evacuation
7. \_\_\_\_ Lack of energy
8. \_\_\_\_ Migrating aches and pain
9. \_\_\_\_ Tire too easily
10. \_\_\_\_ Avoids activity
11. \_\_\_\_ Leg nervousness at night
12. \_\_\_\_ Diminished sex drive

Top 3 symptoms affecting my life:

Foods I crave and/or foods I can’t go without:

Foods I stress eat:

Weight: present (and past if changed)

\_\_\_\_\_\_lbs\_\_\_\_\_\_lbs(past)

Women: Describe menstrual cycle.

 Length, Flow, Symptoms- Past & Present:

Antibiotic use: (last year total & lifetime total)

 Prescription meds *present*:

 (Please list condition, not meds)

Prescription meds *past*:

 (Please list condition, not med)

 Over-the-counter:

(vitamins, herbs, aspirin, etc.)

 List: root canals/major dental work completed:

List stressors contributing to your symptom:

(trauma, conflict, work, family, anxiety, etc.)

**Please scan and email -or- fax -or- mail to:**

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