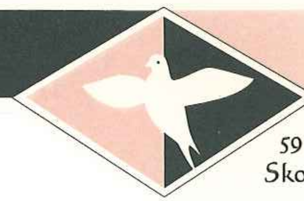
Gerald E. Vermette, d.d.s., f.a.g.d.



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SYMPTOM QUESTIONNAIRE

Rate each of the following symptoms based upon your health profile for the past 30 days.

Point Scale

0=Never or almost never have the symptom
1=Occasionally have it, effect is not severe
2=Occasionally have it, effect is severe
3=Frequently have it, effect is not severe
4=Frequently have it, effect is severe

NAME________________________

SYMPTOM	Date	Date	Date	Date
Digestive Tract:				
Nausea or Vomiting				
Diarrhea				
Constipation				
Bloated Feeling				
Belching or Passing Gas				
Crohns Disease				
Graves Disease				
Heartburn				
Colitis				
Abdominal Pain				
Blood in Stool				
Ulcer				
Poor Appetite				
Ears:				
Itchy Ears				
Earaches, Ear Infections				
Drainage from Ears				
Noises in Ears				
Hissing in Ears				
Hearing Problems				
Ringing in Ears				
Emotions:				
Mood Swings				
Depression				
Suicidal Tendencies				
Anxiety, Fear or Nervousness				
Anger				
Divorced				
Irritability or Aggressiveness				
Energy/Activity:				
Fatigue/Sluggishness				

SYMPTOM	Date	Date	Date	Date
Hyperactivity				
Tire Easily				
Apathy, Lethargy				
Restlessness				
Tired when Awaken in morning				
Eyes:				
Watery or Itchy				
Bags or Dark Circles under Eyes				
Swollen, Red or Sticky				
Blurred or Tunnel Vision				
Head:				
Headaches				
Dizziness				
Faintness				
Insomnia				
Heart:				
Heart Attack				
Heart Murmur				
Endocarditis				
High Blood Pressure				
Abnormal EKG (Electrocardiogram)				
Heart or Chest Pain				
Partial Heart Block				
Angina				
Low Blood Pressure				
Tachycardia(Racing Heart Beat)				
Joint/Muscle:				
Pain or Aches in Joint				
Cramps in Legs				
Stiffness or Limitation of Movement				
Pains or Aches in Muscles				
Feeling of Weakness or Tiredness				
Arthritis				
Osteoporosis				
Lungs:				
Chest Congestion				
Difficulty Breathing				
Pneumonia 1 or more times per year				
Laryngitis 1 or more times per year				
Bronchitis 1 or more times per year				
Shortness of Breath				
Asthma				

SYMPTOM	Date	Date	Date	Date
Mind:				
Poor Memory				
Learning Disabilities				
Confusion, Poor Comprehension				
Poor Physical Coordination				
Poor Concentration				
Slurred Speech				
Difficulty Making Decisions				
Stuttering or Stammering				
Mouth/Throat:				
Metallic Taste in Mouth				
Decreased Saliva				
Chronic Coughing				
Canker Sores				
Gagging, Often need to Clear Throat				
Swollen or Discolored Tongue, Gums or Lips				
Bleeding Gums				
Loosening of Teeth, Periodontal Disease				
Increased Saliva				
Sore Throat				
Loss of Voice				
Hoarseness				
Nose:				
Stuffy Nose				
Sinus Problems				
Bloody Nose				
Hay Fever				
Sneezing Attacks				
Loss of Smell				
Excessive Mucus Formation				
Dry, Crusty Membranes				
Skin:				
Unexplained Rashes				
Red Flushes of Color				
Acne, Pimples				
Hair Loss				
Excessive itching				
Rough Skin				
Hives				
Excessive Sweating				

SYMPTOM	Date	Date	Date	Date
Weight:				
Binge Eating/Drinking				
Excessive Weight				
Water Retention				
Craving Certain Foods				
Compulsive Eating				
Under Weight				
Endocrine:				
Thyroid, under or over Active				
Low Female Hormones				
Cold Hands or Feet				
Pancreas, Blood Sugar Low or Pancreatitis				
Diabetes				
Prostrate Problems				
Menstruation, painful, too often, to seldom				
Chronically Sub-Normal Temperature				
Immune System:				
Auto Immune Disease				
Low Immune Disease				
Allergies				
Nervous Disorders:				
Multiple Sclerosis				
Shingles(Herpes Zoster)				
Numbness in any part of Body				
Tingling in any part of Body				
Dr. told you "It's Your Nerves"				
Twitching of face or Other Muscles				
Bells Palsy				
Knees or Leg Jerk				
Burning Pain				
Epilepsy or Convulsions				
Tremor of Hands, Feet or Head				
Blood Diseases:				
Mononucleosis				
False Positive for Venereal Disease				
Cancer:				
Leukemia				
Hodgkin's Disease				
Any Other (Name:)				