

Date:    /    /   

**Healthy Subjects, Symptom History Form**

**Subject ID:** \_\_\_\_\_

*(Please circle the symptoms that you experience.)*

Table. Symptom Score

<b>Digestive Symptom</b>	<b>Absent</b>	<b>Present</b>
Abdominal Pain	0	1
Acid Reflux	0	1
Acidic Stomach	0	1
Altered Bowel Habits	0	1
Bloating	0	1
Burping/Belching	0	1
Constipation	0	1
Dark Urine	0	1
Diarrhea	0	1
Difficulty Swallowing	0	1
Feeding Difficulties	0	1
Flatus/Wind/Excess Gas	0	1
Food Intolerance	0	1
Heartburn	0	1
Indigestion	0	1
Irregular Bowel movements	0	1
Lack of Appetite	0	1
Nausea	0	1
Need for Laxatives	0	1
Pain during bowel movement	0	1
Rectal Bleeding	0	1
Vomiting	0	1
Weight Gain	0	1

Weight Loss	0	1
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**Range of digestive symptoms score: 0 – 24**

<b>Non-digestive Symptom:</b>	<b>Absent</b>	<b>Present</b>
<b>General</b>		
Persistent/Recurrent Fever	0	1
Fatigue/Malaise	0	1
Night Sweats	0	1

**Range: 0-3**

<b>Non-digestive Symptom:</b>	<b>Absent</b>	<b>Present</b>
<b>Eyes</b>		
Trouble Seeing	0	1
Eye Pain	0	1
Inflamed Eyes	0	1
Double Vision	0	1

**Range: 0-4**

<b>Non-digestive Symptom:</b>	<b>Absent</b>	<b>Present</b>
<b>Ears</b>		
Loss of Hearing	0	1
Ringing in the Ears	0	1
Discharge	0	1

**Range: 0-3**

<b>Non-digestive Symptom:</b>	<b>Absent</b>	<b>Present</b>
<b>Nose</b>		
Loss of Smell	0	1
Frequent Colds	0	1
Obstructions	0	1

Excess Discharge	0	1
Nosebleeds	0	1

**Range: 0-5**

<b>Non-digestive Symptom:</b>	<b>Absent</b>	<b>Present</b>
<b>Mouth</b>		
Sore or Bleeding Gums	0	1
Soreness of Tongue	0	1
Toothache	0	1

**Range: 0-3**

<b>Non-digestive Symptom:</b>	<b>Absent</b>	<b>Present</b>
<b>Throat</b>		
Postnasal Drip	0	1
Soreness	0	1
Hoarseness	0	1

**Range: 0-3**

<b>Non-digestive Symptom:</b>	<b>Absent</b>	<b>Present</b>
<b>Breasts</b>		
Lumps	0	1
Discharge	0	1

**Range: 0-2**

<b>Non-digestive Symptom:</b>	<b>Absent</b>	<b>Present</b>
<b>Nervous System</b>		
Anxiety	0	1
Headaches	0	1
Dizziness	0	1
Fainting	0	1
Convulsions or Seizures	0	1

Nervousness	0	1
Sleeplessness	0	1
Depression	0	1
Change in Sensation	0	1
Memory Loss	0	1
Poor Coordination	0	1
Weakness or Paralysis	0	1
Brain Fog	0	1

**Range: 0-13**

<b>Non-digestive Symptom:</b>	<b>Absent</b>	<b>Present</b>
<b>Cardio Respiratory Systems</b>		
Cough Persisting	0	1
Sputum (Phlegm)	0	1
Bloody Sputum	0	1
Wheezing	0	1
Chest Pain or Discomfort	0	1
Pain on Breathing	0	1
Difficulty Breathing while lying down	0	1
Swelling of Ankles	0	1
Bluish Finger or Lips	0	1
High Blood Pressure	0	1
Palpitations	0	1

**Range: 0 – 11**

<b>Non-digestive Symptom:</b>	<b>Absent</b>	<b>Present</b>
<b>Locomotor</b>		
Muscle Cramps	0	1

Muscle Weakness	0	1
Pain in Joints	0	1
Swollen Joints	0	1
Stiffness	0	1
Deformity of Joints	0	1
Back Pain	0	1

**Range: 0-7**

<b>Non-digestive Symptom:</b>	<b>Absent</b>	<b>Present</b>
<b>Skin</b>		
Eruptions (Rash)	0	1
Change in Color	0	1
Change in Hair	0	1
Change in Nails	0	1

**Range: 0-4**

<b>Non-digestive Symptom:</b>	<b>Absent</b>	<b>Present</b>
<b>Genitourinary System</b>		
Increase in Frequency of Urination Day/Night	0	1
Feel Need to Urinate Without Much Urine	0	1
Unable to Hold Urine	0	1
Pain or burning	0	1
Blood in Urine	0	1
Impotence	0	1
Lack of Sex Drive	0	1
Pain with Intercourse	0	1

**Range 0-8**

**Range of non-digestive symptoms score: 0 – 66**

