Natural Health
Improvement Center of North Florida

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Heart Sound Recorder Survey

Name: ______________________________ Date: _______________

Circle the Corresponding Number:
If a symptom does not apply, do not circle anything for that symptom.

1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

1. 1 2 3 Ringing in ears
2. 1 2 3 Dizziness
3. 1 2 3 Tired throughout day
4. 1 2 3 Swollen ankles
5. 1 2 3 Poor circulation
6. 1 2 3 Breathing challenges

7. 1 2 3 Afternoon “yawner”
8. 1 2 3 Difficulty catching breath, especially during exercise
9. 1 2 3 Aware of “breathing heavily”
10. 1 2 3 Tightness or pressure in chest, worse on exertion
11. 1 2 3 Fatigue upon exertion
12. 1 2 3 Hands and feet go to sleep easily, numbness
13. 1 2 3 Muscle weakness
14. 1 2 3 Muscle cramps, worse during exercise, get “charley horse”
15. 1 2 3 Muscle spasms

16. 1 2 3 Heart pounds at night
17. 1 2 3 Heart races after alcohol consumption
18. 1 2 3 Heart races

19. 1 2 3 Heart flutters
20. 1 2 3 Sensitive to cold

Yes No Daily bowel movement

<u>Are you taking any of the following medications?</u>

Yes No Cholesterol If yes, name of medication: ____

Yes No Blood pressure If yes, name of medication: ____

Yes No Blood sugar If yes, name of medication: ____

Yes No Other If yes, name of medication: ____

Yes No **<u>Are you taking any additional supplements?</u>** If yes, list supplements: ______________________

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