**Symptoms of Illness Checklist (SIC)**

Listed on the following pages are common symptoms of illness. Next to each symptom, there are two columns, titled **“FREQUENCY”** and **“IMPACT ON DAILY ACTIVITIES”**. For each symptom, please mark each of the columns according to the guidelines below.

|  |  |
| --- | --- |
| **FREQUENCY** | **IMPACT ON DAILY ACTIVITIES** |
| Circle the appropriate letter corresponding to the frequency with which you have experienced the symptom over the past **two months** according to the following: | Circle the appropriate letter corresponding to the impact of the symptom, according to the following: |
|  | G = Did not have the symptom |
| A = Did not have the symptom  B = 1-3 days during the past 2 months | H = Symptom present, but didn’t interfere with daily activities |
| C = 4-7 days during the past 2 months  D = 8-14 days during the past 2 months | I = Symptom slightly interfered with daily activities |
| E = 15-49 days during the past 2 months  F = 50-60 days (daily) during the past 2 months | J = Symptom considerably interfered with daily activities  K = Symptom severely interfered with daily activities |

**Frequency**

A = Did not have the symptom

B = 1-3 days during the past 2 months

C = 4-7 days during the past 2 months

D = 8-14 days during the past 2 months

E = 15-49 days during the past 2 months

F = 50-60 days (daily) during the past 2 months

**Impact on daily activities (IMPACT)**

G = Did not have the symptom

H = Symptom present, but didn’t interfere with daily activities

I = Symptom slightly interfered with daily activities

J = Symptom considerably interfered with daily activities

K = Symptom severely interfered with daily activities

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SYMPTOM** | **FREQUENCY** | | | | | | **IMPACT** | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 1. Sore Throat | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 2. High Blood Pressure | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 3. Ear Problems (ear ache or pain, ringing or buzzing in ears, etc.) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 4. Muscle aches or pain not due to strenuous exercise or joints | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 5. Joint (not muscle) problems (stiffness, pain, swelling, etc.) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 6. Cough due to illness | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 7. Respiratory problems other than cough (wheezing, trouble breathing, shortness of breath, etc.) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 8. Back and neck problems (back aches, backpain, etc.) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 9. Sleeping Problems (trouble falling asleep, insomnia,  etc.) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 10. Abdominal pain (due to ulcers, acid indigestion, appendicitis, etc.) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 11. Feeling exhausted or fatigued | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 12. Blood in feces | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 13. Skin rash anywhere on the body | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |

**Frequency**

A = Did not have the symptom

B = 1-3 days during the past 2 months

C = 4-7 days during the past 2 months

D = 8-14 days during the past 2 months

E = 15-49 days during the past 2 months

F = 50-60 days (daily) during the past 2 months

**Impact on daily activities (IMPACT)**

G = Did not have the symptom

H = Symptom present, but didn’t interfere with daily activities

I = Symptom slightly interfered with daily activities

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|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |
| **SYMPTOM** | **FREQUENCY** | | | | | | **IMPACT** | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 14. Urinary problems (painful urination, blood in urine, etc.) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 15. Lightheaded, faint, dizzy | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 16. Chest Pain | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 17. Constipation | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 18. Diarrhea | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 19. Eye problems (redness, impaired, discharge or usually blurry vision, etc.) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |

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| 20. Dental problems (bleeding or discomfort in gums,  teeth or mouth; canker sores, etc.) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 21. Sinus problems | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 22. Nasal problems (runny nose, congested nasal passages, etc.) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 23. Nausea (stomach sickness, inclination to vomit, etc.) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 24. Headaches (migraines, other) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 25. Fever | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 26. Swollen ankles or feet | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 27. Muscle twitching | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |

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|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | | | | |  | | | | |
| **SYMPTOM** | **FREQUENCY** | | | | | | **IMPACT** | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 28. Cold sores | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 29. Numbness/tingling in hands or feet | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 30. Menstrual Problems | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 31. Change in appetite (loss of appetite, overeating, etc.) | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 32. Swollen glands in neck | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |
| 33. Other (if not included above):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **A** | **B** | **C** | **D** | **E** | **F** | **G** | **H** | **I** | **J** | **K** |
|  |  |  |  |  |  |  |  |  |  |  |  |

**Supplemental Health Form**

**(NOTE: This is not part of the SIC, but may used to collect other important demographic and health-related information)**

|  |  |
| --- | --- |
| ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sex (M/F): \_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnic Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Generally speaking, how would you rate your present health? (Please circle one of the following descriptions)

**Good Fair Poor Very Poor**

Compared to others your same age and sex, how would rate your general health? (Please circle one of the following): **Excellent Above Average Average Below Average Very Poor**

**LIST ILLNESSES OR HOSPITALIZATION WITHIN THE PAST YEAR**

|  |  |  |  |
| --- | --- | --- | --- |
| **DISEASE** (Circle “Y” if yes, “N” if no) | **CURRENT STATUS** (Circle one) | | |
| High Blood Pressure..................................................... Y / N | Remission/Cure | Stable | Progressing |
| Coronary Heart Disease................................................ Y / N | Remission/Cure | Stable | Progressing |
| Depression..................................................................... Y / N | Remission/Cure | Stable | Progressing |
| Cancer: ......................................................................... Y / N | Remission/Cure | Stable | Progressing |
| List Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Diabetes......................................................................... Y / N | Remission/Cure | Stable | Progressing |
| Disorder of the G.I. system, including intestine,  stomach, or esophagus........................................... Y / N | Remission/Cure | Stable | Progressing |
| List Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Other: |  |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Remission/Cure | Stable | Progressing |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Remission/Cure | Stable | Progressing |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Remission/Cure | Stable | Progressing |
|  |  |  |  |
|  |  |  |  |

Please list any prescription, or over the counter drugs you are currently using (including birth control, aspirin, pain medications, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times have you been to a doctor or health practitioner in the last two months? \_\_\_\_\_\_\_\_\_\_\_

Women: Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last menstrual period:\_\_\_\_\_\_\_\_\_\_\_\_\_\_