Please look at the list of physical symptoms below and **check off any that you have experienced in the last several days**. If you have **NOT** experienced any symptoms in an area, be sure to check "None of the above" for that area.

Constitutional	Eyes	Ears, Nose, Mouth, & Throat
☐ Chronic pain	☐ Eye pain	☐ Earache
☐ Loss of appetite	☐ Eye discharge	☐ Tinnitus (Ringing in ears)
☐ Increase in appetite	☐ Eye redness	☐ Decreased hearing or hearing loss
☐ Unexplained weight loss	☐ Blurred or double vision	☐ Frequent ear infections
☐ Weight gain	☐ Visual change	☐ Frequent nose bleeds
☐ Fatigue/Lethargy	☐ History of eye surgery	☐ Sinus congestion
☐ Unexplained fever	☐ Sensitivity to light	☐ Runny nose/Post-nasal drip
☐ Hot or Cold spells	☐ Scotomas (blind spots)	☐ Difficulty swallowing
☐ Night sweats	☐ Retinal hemorrhage (floaters in vision)	☐ Frequent sore throat
☐ Sleeping pattern disruption		☐ Prolonged hoarseness
☐ Malaise (flu-like or vague sick feeling)		☐ Pain in jaw or tooth
		☐ Dry mouth
☐ None of the above constitutional issues	☐ None of the above eye issues	☐ None of the above ear, nose, mouth or throat issues

Cardiovascular	Respiratory	Musculoskeletal
☐ Chest pain	☐ Pain with breathing	☐ Swelling in joints
☐ Pacemaker	☐ Chronic cough	☐ Redness of joints
☐ Palpitations (fast or irregular heartbeat)	☐ Chronic shortness of breath	☐ Other joint pains or stiffness

Cardiovascular	Respiratory	Musculoskeletal
☐ Swollen feet or hands	☐ Chronic wheezing/Asthma	☐ Muscle pain or cramping
☐ Fainting spells	☐ Excessive phlegm	☐ Muscle weakness
☐ Shortness of breath with exercise	☐ Coughing blood	☐ Muscle stiffness
	☐ Nocturnal Dyspnea(Shortness of breath at night)	☐ Decreased range of motion
		☐ Back pain or stiffness
		☐ History of fractures
		☐ Past injury to spine or joints
☐ None of the above cardiovascular issues	☐ None of the above respiratory issues	☐ None of the above musculoskeletal issues

Gastrointestinal		
☐ Excessive flatulence or belching	☐ Heartburn	☐ Change in appearance of stool
☐ Diarrhea	☐ Difficulty swallowing solids or liquids	☐ Blood in stool
☐ Constipation	☐ Recent loss in appetite	☐ Dark/Tarry stool
☐ Persistent nausea/vomiting	☐ Sensitivity to milk products	☐ Loss of bowel control/soiling
☐ Abdominal Pain	☐ Jaundice (yellow skin)	☐ None of the above gastrointestinal issues

Allergic/Immunologic	Endocrine	Hematologic/Lymphatic
☐ Frequent infections	☐ Severe menopausal symptoms	☐ Blood clots
☐ Hives	☐ Cold or heat intolerance	☐ Excess/easy bleeding (surgery, dental work, brushing teeth, scrapes)
☐ Anaphylaxic reaction	☐ Excessive appetite	☐ History of blood transfusion
	☐ Excessive thirst or urination	☐ Excessive bruising
	☐ Excessive sweating	☐ Swollen glands (neck, armpits, groin)

Allergic/Immunologic	Endocrine	Hematologic/Lymphatic
☐ None of the above allergic or immunologic issues	☐ None of the above endocrine issues	☐ None of the above hematologic or lymphatic issues

Genitourinary (General)	Genitourinary (Women)	Genitourinary (Men)
☐ Loss of urine control (including bed-wetting)	☐ Unusual vaginal discharge	☐ Slow urine stream
☐ Painful/Burning urination	☐ Vaginal pain, bleeding, soreness, or dryness	☐ Scrotal pain
☐ Blood in urine	☐ Genital sores	☐ Lump or mass in the testicles
☐ Increased frequency of urination	☐ Heavy or irregular periods	☐ Abnormal penis discharge
☐ Up more than twice/night to urinate	☐ No menses (Periods stopped)	☐ Trouble getting/maintaining erections
☐ Urine retention	☐ Currently pregnant	☐ Inability to ejaculate/orgasm
☐ Frequent urine infections	☐ Sterility/Infertility	☐ Any other sexual or sex organ concerns
	☐ Any other sexual or sex organ concerns	
☐ None of the above general genitourinary issues	☐ None of the above sex-specific genitourinary issues	☐ None of the above sex-specific genitourinary issues

Neurological	Integumentary (Skin/Breast and Hair)	Psychiatric
☐ Paralysis	☐ Lesions	☐ Hallucinations/Delusions
☐ Fainting spells or blackouts	☐ Unusual mole	☐ Feeling depressed
☐ Dizziness/Vertigo	☐ Easy bruising	☐ Difficulty concentrating
☐ Drowsiness	☐ Increased perspiration	☐ Phobias/Unexplained fears
☐ Slurred speech	☐ Rashes	☐ No pleasure from life anymore
☐ Speech problems (other)	☐ Chronic dry skin	☐ Anxiety
☐ Short term memory trouble	☐ Itchy skin or scalp	☐ Insomnia
☐ Memory difficulties (loss)	☐ Hair or nail changes	☐ Excessive moodiness

Neurological	Integumentary (Skin/Breast and Hair)	Psychiatric
☐ Frequent headaches	☐ Hair loss	☐ Stress
☐ Muscle weakness	☐ Breast tenderness	☐ Disturbing thoughts
☐ Numbness/Tingling sensations	☐ Breast discharge	☐ Manic episodes
☐ Neuropathy (numbness in feet)	☐ Breast lump or mass	☐ Confusion
☐ Tremor in hands/shaking		☐ Memory loss
☐ Muscle spasms or tremors		☐ Nightmare
☐ None of the above neurological issues	☐ None of the above integumentary issues	☐ None of the above psychiatric issues

Do you have a history of any of the following health problems? (Please check all that apply)

☐ No Problems	☐ Fibromyalgia	☐ Kidney Disease
	☐ Gall Bladder disease	☐ Kidney Stones
☐ Allergies	☐ Gastritis or Ulcer	☐ Liver disease (other)
☐ Anemia (low blood count)	☐ Glaucoma	☐ Lupus
☐ Arthritis	☐ Gout	☐ Migraine Headaches
☐ Asthma	☐ Hearing Loss	☐ Multiple Sclerosis
☐ Back problems (including disk or spine)	☐ Heart disease	☐ Obesity / Overweight
☐ Cancer : _____(location)	☐ Heart defect from birth	☐ Parkinson's Disease
☐ Cataracts	☐ Heart valve problems	☐ Polyps
☐ Chickenpox (as a child)	☐ Hemorrhoids	☐ Seizures
☐ Chronic Bronchitis	☐ Hepatitis	☐ Sexually Transmitted Disease (STD)
☐ COPD (Emphysema)	☐ Hernia	☐ Sleep apnea [ ] use of CPAP?

☐ Diabetes	☐ HIV	☐ Stroke/TIA
☐ Diverticulitis	☐ Hypertension (High blood pressure)	☐ Testosterone (low)
☐ Fainting spells/ Passing out	☐ Hypotension (Low blood pressure)	☐ Thyroid problems (hypo or hyperthyroid)
☐ High cholesterol	☐ Inflammatory Bowel Disease	☐ Tuberculosis or exposure to tuberculosis
[ ] Head injuries X _____	☐ Iron deficiency	

Have you a history of surgery in any of the following areas? (Please check all that apply)

☐ No surgical history	☐ Hip [ ] Knee [ ]Ankle [ ]Foot	☐ Penis
	☐ Hysterectomy (Ovaries Removed)	☐ Prostate
☐ Back/Neck	☐ Hysterectomy (Ovaries Retained)	☐ Sex Change
☐ Brain	☐ Intestine	☐ Shoulder [ ]Elbow [ ]Wrist [ ]Hand
☐ Cardiac	☐ Kidney	☐ Stomach
☐ Ear [ ]Nose [ ]Throat	☐ Liver	☐ Tonsils
☐ Gall Bladder	☐ Lung	☐ Vagina
☐ Hernia	☐ Pancreas	☐ Weight Loss
[ ] Other:	☐ Pelvis	[ ] Other:

Please note date of surgeries, location (right/left) and any other surgeries that you've had in the past that is not listed above.

_____

_____

_____

_____

Women's Health

1. Age at onset of periods: _____ 1st day of last period: _____ If no menses; when did periods stop? _____

2. Date of last Pap smear: _____ Date of last mammogram: _____

3. Total pregnancies: _____ Total live births: _____ Total miscarriages: _____ Total abortions: _____

4. Total C-sections: _____

5. Which of these best describe your premenstrual symptoms?

- ☐ None of these
- ☐ Dysphoria – sudden and transient state of mind, such as feelings of sadness, anguish, sorrow
- ☐ Cramps
- ☐ Appetite change
- ☐ Bloating
- ☐ Sleep disturbance

6. Do you have a method of contraception? (check all that apply)

- ☐ No method of contraception
- ☐ Intrauterine (e.g., IUD)
- ☐ Hormonal (e.g., implant, injection, "the pill," patch, hormonal vaginal contraceptive ring)
- ☐ Barrier (e.g., diaphragm, male/female condom, spermicide)
- ☐ Fertility Awareness-based (e.g., natural family planning)
- ☐ Permanent (e.g., male/female sterilization, infertility)
- ☐ Other: _____