Do you currently have any of the following? Circle the corresponding yes or no

 Comments

Yes No Generally Healthy

Yes No Recent weight gain or loss of 25lbs or more

Yes No Fever

Yes No Vision problems (Excluding glasses)

Yes No Sinus Problems

Yes No Hearing loss

Yes No Chest Pain

Yes No Varicose veins

Yes No Shortness of breath

Yes No Chronic Cough

Yes No Diarrhea

Yes No Constipation

Yes No Blood in stools

Yes No Heartburn/reflux

Yes No Frequent urination

Yes No Burning with urination

Yes No Incontinence

Yes No Urgency

Yes No Bladder Infection

Yes No Stomach pains

Yes No Vaginal discharge

Yes No Irregular vaginal bleeding

Yes No Pelvic Pain

Yes No Painful intercourse

Yes No Breast lumps

Yes No Back pain

Yes No Joint/muscle pain

Yes No Depression/Anxiety

None of the Above