

Surgeries (type of and date):

Significant Trauma (auto accidents, falls etc.):

Allergies (drugs, chemicals, foods/result):

Family Medical History (check):

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Stroke	<input type="checkbox"/> Allergies
<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other:
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	
<input type="checkbox"/> Heart Disease		

Medicines/supplements taken within the last month (vitamins, drugs, herbs, etc.):

1) Current medications (names & dosages):

2) Vitamins/supplements/herbs:

3) Do you have a regular exercise program? Please describe:

Please Describe Your Average Daily Diet:

Morning:

Afternoon:

Evening:

1) How many packs of cigarettes do you smoke per day?

2) How much coffee, tea or cola do you drink per week? Alcohol?

3) Rate your stress levels on a scale of 1-10 during an average week:

4) Please describe any use of drugs for non-medical purposes:

DIRECTIONS : Please Check The Appropriate Box For Any Symptoms You Have Had in the Last Few Months.

Mild/Infrequent ① ② ③ Severe/Frequent

GENERAL

<input type="checkbox"/> ① ② ③ Chills	<input type="checkbox"/> ① ② ③ Poor sleeping	<input type="checkbox"/> ① ② ③ Lack of coordination
<input type="checkbox"/> ① ② ③ Sweat easily	<input type="checkbox"/> ① ② ③ Poor appetite	<input type="checkbox"/> ① ② ③ Loss of balance
<input type="checkbox"/> ① ② ③ Night sweats	<input type="checkbox"/> ① ② ③ Weight gain	<input type="checkbox"/> ① ② ③ Vertigo/dizziness
<input type="checkbox"/> ① ② ③ Bleed or bruise easily	<input type="checkbox"/> ① ② ③ Weight loss	<input type="checkbox"/> ① ② ③ Areas of numbness
<input type="checkbox"/> ① ② ③ Strong thirst (hot or cold drinks)	<input type="checkbox"/> ① ② ③ Dental/gum problems	<input type="checkbox"/> ① ② ③ Poor memory
<input type="checkbox"/> ① ② ③ Fatigue	<input type="checkbox"/> ① ② ③ Seizures	

SKIN and HAIR

<input type="checkbox"/> ① ② ③ Itching	<input type="checkbox"/> ① ② ③ Recent moles	<input type="checkbox"/> ① ② ③ Loss of hair/thinning
<input type="checkbox"/> ① ② ③ Eczema	<input type="checkbox"/> ① ② ③ Loss of hair/thinning	<input type="checkbox"/> ① ② ③ Dandruff
<input type="checkbox"/> ① ② ③ Hives	<input type="checkbox"/> ① ② ③ Dandruff	
<input type="checkbox"/> ① ② ③ Acne		

Other hair or skin problems:

HEAD, EYES, EARS, NOSE and THROAT

<input type="checkbox"/> ① ② ③ Dizziness	<input type="checkbox"/> ① ② ③ Spots in front of eyes	<input type="checkbox"/> ① ② ③ Nose bleeds
<input type="checkbox"/> ① ② ③ Migraines	<input type="checkbox"/> ① ② ③ Eye pain	<input type="checkbox"/> ① ② ③ Sinus congestion

① ② ③ Headaches ① ② ③ Poor vision ① ② ③ Blurry vision ① ② ③ Night blindness	① ② ③ Cataracts ① ② ③ Hearing loss ① ② ③ Ringing in ears ① ② ③ Earaches	① ② ③ Grinding teeth ① ② ③ Recurrent sore throats/colds ① ② ③ Concussion
Other head or neck problems:		
CARDIOVASCULAR		
① ② ③ High blood pressure ① ② ③ Low blood pressure ① ② ③ Chest discomfort/pain ① ② ③ Heart palpitations	① ② ③ Cold hands or feet ① ② ③ Swelling of hands or feet ① ② ③ Blood clots	① ② ③ Fainting ① ② ③ Difficulty in breathing ① ② ③ Varicose/spider veins
Other heart or blood vessel problems:		
RESPIRATORY		
① ② ③ Production of phlegm? **What color: _____	① ② ③ Cough ① ② ③ Asthma/wheezing ① ② ③ Pneumonia ① ② ③ Bronchitis	Other respiratory problems:
GASTROINTESTINAL		
① ② ③ Bad breath ① ② ③ Nausea ① ② ③ Vomiting ① ② ③ Belching ① ② ③ Bloating	① ② ③ Acid reflux/GERD ① ② ③ Diarrhea/Loose stools ① ② ③ Constipation ① ② ③ Abdominal pain/cramps	① ② ③ Intestinal gas ① ② ③ Rectal pain ① ② ③ Hemorrhoids ① ② ③ History of gallbladder attacks or stones
Other stomach or intestinal problems:		
GENITO-URINARY		
① ② ③ Pain on urination ① ② ③ Urgency to urinate ① ② ③ Frequent urination ① ② ③ Blood in urine ① ② ③ Burning urination ① ② ③ Urinary tract infection ① ② ③ Prostatitis ① ② ③ Decrease in flow	① ② ③ Unable to hold urine ① ② ③ Dribbling ① ② ③ Kidney stones ① ② ③ Pain in testicles ① ② ③ Impotency ① ② ③ Change in sexual drive	① ② ③ Decreased libido ① ② ③ Excessive libido ① ② ③ Genital sores ① ② ③ Herpes Do you wake up to urinate? <input type="checkbox"/> Yes <input type="checkbox"/> No How often? : _____
Other genital or urinary system problems:		
GYNECOLOGY/REPRODUCTIVE		
____ Number of pregnancies ____ Number of births ____ Number of ectopic pregnancies ____ Number of Miscarriages ____ Number of Abortions ____ Age of first menses ____ Period between menses Duration _____ Date of last menses _____ Menstrual flow: <input type="checkbox"/> heavy <input type="checkbox"/> light <input type="checkbox"/> moderate ① ② ③ Increased vaginal pain, dryness or itching	① ② ③ Painful periods ① ② ③ Irregular periods ① ② ③ Clots ① ② ③ PMS ① ② ③ Nipple discharge ① ② ③ Breast lumps ____ Menopause: **Age: _____ **Year: _____ ① ② ③ Hot flashes ① ② ③ Unusual vaginal discharge	① ② ③ Vaginal sores ① ② ③ Painful intercourse ① ② ③ Infertility ① ② ③ Ovarian cysts ① ② ③ Endometriosis ① ② ③ Uterine fibroids ① ② ③ Polycystic Ovarian Disease ① ② ③ Facial hair growth Date of last Pap/pelvic? Do you practice birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No What type and for how long?
Other GYN problems:		

MUSCULOSKELETAL

① ② ③ Neck pain	① ② ③ Hand/wrist/arm pain	① ② ③ Foot/ankle pains
① ② ③ Shoulder pain	① ② ③ Hip pain	① ② ③ Muscle pains
① ② ③ Back pain	① ② ③ Knee pain	① ② ③ Muscle weakness
① ② ③ Sciatica		

Other Musculoskeletal problems:

PSYCHOLOGICAL

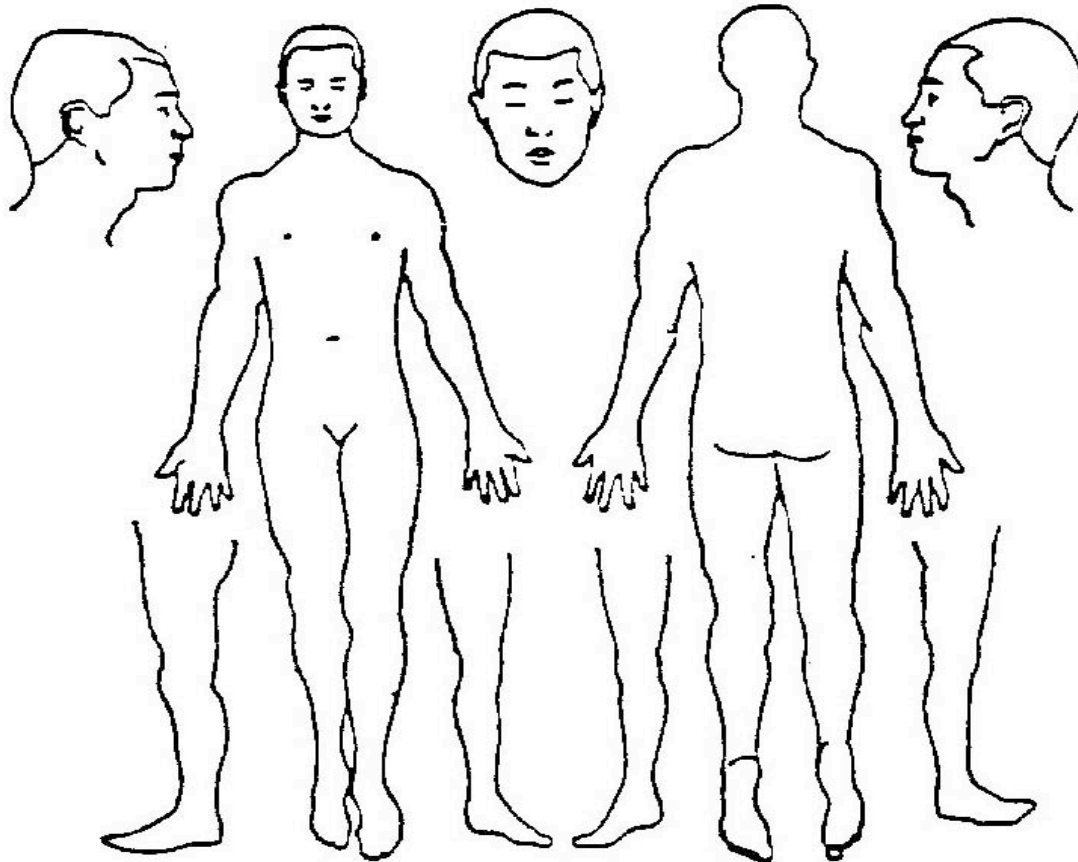
① ② ③ Irritable	① ② ③ Easily susceptible to stress	① ② ③ Anxiety
① ② ③ Depression		① ② ③ ADD/ADHD
① ② ③ Manic depression		① ② ③ Seasonal affective disorder

Other Psychological problems:

Other neurological or psychological problems:

- 1) Have you ever been treated for emotional problems?
 Yes No
- 2) Have you ever considered or attempted suicide?
 Yes No
- 3) Have you ever been treated for substance abuse?
 Yes No

Indicate painful or distressed areas:



Comments (any other problems you would like to discuss):

Empty rectangular box for providing additional comments or details.