PLEASE CHECK ANY CONDITIONS YOU HAVE EXPERIENCED WITHIN THE LAST SIX MONTHS. INDICATE THE LENGTH OF TIME YOU HAVE HAD THIS CONDITION.

Example: ☐ Insomnia 3 months

GENERAL

☐Poor appetite ___________ ☐Weight Gain __________ ☐Weight loss ____________

☐ Insomnia _____________ ☐Disturbed sleep ________ ☐ Night sweat ___________

☐ Fever ________________ ☐Chills________________ ☐Sweat easily ____________

☐Changes in appetite _____ ☐Cravings _____________ ☐Strong thirst_____________

☐Tremors ______________ ☐Poor balance __________ ☐Localized sleep _________

☐Sudden energy drop (time of day?) ________ ☐Bleeding or bruising easily _________

Other unusual or abnormal conditions you have noticed in your general sense of health:

____

____

SKIN AND HAIR

☐ Rashes ________________ ☐Eczema ______________ ☐Recent moles ___________

☐Ulcerations _____________ ☐ Pimples _____________ ☐Hives _________________

☐Dandruff _______________ ☐Itching ______________ ☐Hair loss _______________

☐Changes in texture of hair or skin ____

Other problem: ____

____

HEAD, EYES, EARS, NOSE, THROAT

☐ Headaches(where?,When?)____

____

☐Migraines _____________ ☐Concussions ___________ ☐Dizziness _______________

☐ Color blindness ______ ☐Blurry vision___________ ☐ Cataracts _______________

☐ Glasses ______________ ☐Spots in front of eyes ___ ☐Eye pain________________

☐ Poor vision ___________ ☐Eye strain _____________ ☐ Night blindness __________

☐ Nose bleeds __________ ☐Sinus problems _______ ☐Facial pain ______________

☐Grinding teeth _______ ☐ Teeth problems _______ ☐Sores on lips or tongue ___

☐Earaches ____________ ☐ Ringing in ears ________ ☐Poor hearing____________

☐ Recurrent sore throat____________________________ ☐Jaw clicks _______________

Any other head or neck problems: ____

____

CARDIOVASCULAR

☐Dizziness _________ ☐High blood pressure ______ ☐Low blood pressure _______

☐ Swelling of feet ____ ☐Cold hands or feet _______ ☐Swelling of hands _________

☐ Fainting ___________ ☐ Blood clots _____________ ☐Phlebitis __________________

☐ Chest pain ________ ☐Difficulty in breathing _____☐Irregular heart beat ________

Any other heart or blood vessel problems? ____

____

RESPIRATORY

☐ Cough ___________ ☐Bronchitis ______________ ☐Coughing up blood _______

☐ Asthma ___________ ☐Pneumonia _____________ ☐ Excessive phlegm (color?)__

☐Difficulty breathing when lying down___________☐Pain with deep inhalation ______

Any other lung problems? ____

____

GASTROINTESTINAL

☐ Nausea ___________ ☐Belching ____________ ☐Rectal pain __________________

☐ Vomiting ________ ☐Black stools ________ ☐Hemorrhoids _________________

☐ Diarrhea ________ ☐ Blood in stools ______ ☐Abdominal pain or cramps _____

☐ Constipation _____ ☐ Indigestion __________ ☐Chronic laxative use __________

☐Gas _____________ ☐ Bad breath ____

Any other problems with stomach or intestines? ___________________________________

____

GENITOURINARY

☐ Pain on urination ______ ☐Urgency of urinate _______ ☐Decrease in flow _____

☐Frequent urination ______ ☐Unable to hold urine ______ ☐Impotence __________

☐Blood in urine _________ ☐Kidney stones ___________ ☐ Sores on genitals _____

Do you wake up at night to urinate? ____

Any particular color to your urine? ____

Any other genital or urinary problems? ____

____

REPRODUCTIVE AND GYNECOLOGIC

☐ Premenstrual changes ________________ ☐Heavy menstrual flow _____________

☐Menstrual clots ______________________ ☐Light menstrual flow _____________

☐Painful menses _________ ☐Irregular menses __________ ☐Abortions _________

☐ Unusual menses _______ ☐Other problems _______________________________

Age at first menses: ___________________ Age at first menopause: _______________

Time between cycles: _____ Duration of bleeding: _____ First day of last menses: _____

Number of pregnancies: _______ Miscarriages: ________ Premature births: _________

Do you practice birth control? ____ If so, what type? ___________ For how long? _____

Any other gynecologic problems? ____

____

MUSCULOSKELETAL

☐Neck pain __________ ☐Back pain ____________ ☐Hand/wrist pains __________

☐Muscle pains _______ ☐Muscle weakness ______ ☐Shoulder pains ___________

☐Knee pain __________ ☐Foot/ankle pains _______ ☐Hip pain ________________

Any other joint or bone problems? ____

____

NEUROPHYSICAL

☐Seizures ____________ ☐ Poor memory __________ ☐Anxiety ___________________

☐Dizziness ___________ ☐Lack of coordination ____ ☐Bad temper ________________

☐ Loss of balance ____ ☐Concussion ____________ ☐Easily susceptible to stress ___

☐ Areas of numbness ____________________________ ☐Depression ________________

Have you ever been treated for emotional problems? ________________________________

Have you ever considered or attempted suicide? ____________________________________

Any other neurological or psychological problems? _________________________________

____

COMMENTS

Please list any other problems you would like to discuss: _____________________________

____

____

____

____

____

____

____

____