PATIENT'S PERSONAL HISTORY FORM

NOTE: This is a confidential record and will be kept in this facility or in your doctor's office. Information contained here will not be released to anyone without your authorization to do so.

Name _____ Age _____ Date _____

Occupation _____ Birth Place _____ Date of Birth _____

Doctor _____ Date of Last Physical Evaluation _____

List all States and Countries in which you have lived _____

Chief Complaints: (please list all symptoms)

1. _____ 3. _____

2. _____ 4. _____

FAMILY HISTORY: Has any blood relative ever had any of the following?

Please answer each of the following questions by placing an (X) in the "YES" box if your answer to the question is Yes, or by placing an (X) in the "NO" box if your answer to the question is No. Fill in "who" and "when" information when necessary.

Cancer, including Leukemia	☐ No	☐ Yes	Who _____
Tuberculosis	☐ No	☐ Yes	Who _____
Diabetes	☐ No	☐ Yes	Who _____
Heart Trouble	☐ No	☐ Yes	Who _____
Heart Attack	☐ No	☐ Yes	Who _____
High Blood Pressure	☐ No	☐ Yes	Who _____
Stroke	☐ No	☐ Yes	Who _____
Epilepsy	☐ No	☐ Yes	Who _____
Bleeding Disorder	☐ No	☐ Yes	Who _____
Asthma	☐ No	☐ Yes	Who _____
Migraine Headaches	☐ No	☐ Yes	Who _____
Allergies	☐ No	☐ Yes	Who _____
Liver Disease	☐ No	☐ Yes	Who _____
Alcoholism	☐ No	☐ Yes	Who _____
Emphysema	☐ No	☐ Yes	Who _____
Kidney Disease	☐ No	☐ Yes	Who _____
Glaucoma	☐ No	☐ Yes	Who _____
Sickle Cell Anemia	☐ No	☐ Yes	Who _____
Stomach or Duodenal Ulcer	☐ No	☐ Yes	Who _____
Other Anemia	☐ No	☐ Yes	Who _____
Mental Illness	☐ No	☐ Yes	Who _____
Suicide	☐ No	☐ Yes	Who _____
Birth Defects	☐ No	☐ Yes	Who _____
Other Serious Disease	☐ No	☐ Yes	Who _____

Do you smoke? ☐ No ☐ Yes

If Yes, What? _____ How Much? _____

Did your parents smoke? ☐ No ☐ Yes Who _____

Do you drink? ☐ No ☐ Yes

Beer ☐ No ☐ Yes

Wine ☐ No ☐ Yes

Other Alcoholic Beverages? ☐ No ☐ Yes What? _____

How much of each? _____

Are you on a special diet? ☐ No ☐ Yes

What diet? _____

How many days per week do you exercise _____

What type of exercises do you do? _____

Have you lost weight in the past year? ☐ No ☐ Yes

Do you have difficulty sleeping? ☐ No ☐ Yes

Are you overweight? ☐ No ☐ Yes

Family History

	AGE	LIVING	DEAD	AGE OF DEATH	CAUSE OF DEATH
Paternal Grandfather		☐	☐		
Paternal Grandmother		☐	☐		
Father		☐	☐		
Maternal Grandfather		☐	☐		
Maternal Grandmother		☐	☐		
Mother		☐	☐		
Brother ☐ Sister ☐		☐	☐		
Brother ☐ Sister ☐		☐	☐		
Brother ☐ Sister ☐		☐	☐		
Brother ☐ Sister ☐		☐	☐		
Brother ☐ Sister ☐		☐	☐		
Brother ☐ Sister ☐		☐	☐		
Husband ☐ Wife ☐		☐	☐		
Son ☐ Daughter ☐		☐	☐		
Son ☐ Daughter ☐		☐	☐		
Son ☐ Daughter ☐		☐	☐		
Son ☐ Daughter ☐		☐	☐		
Son ☐ Daughter ☐		☐	☐		
Son ☐ Daughter ☐		☐	☐		

PATIENT'S PERSONAL HISTORY (continued)

X-RAYS: Have you had any of these X-Rays? If so, When?

Chest	☐ No ☐ Yes	When	_____
Stomach	☐ No ☐ Yes	When	_____
Colon	☐ No ☐ Yes	When	_____
Gall Bladder	☐ No ☐ Yes	When	_____
Back	☐ No ☐ Yes	When	_____
Kidney	☐ No ☐ Yes	When	_____
Extremities	☐ No ☐ Yes	When	_____
Other	☐ No ☐ Yes	When	_____
Have you ever had x-ray treatment?	☐ No ☐ Yes	When	_____

IMMUNIZATIONS: Have you ever been immunized against:

Small Pox	☐ No ☐ Yes	Last Shot	_____
Tetanus	☐ No ☐ Yes	Last Shot	_____
Polio (shots or oral vaccine)	☐ No ☐ Yes	Last Shot	_____
Measles	☐ No ☐ Yes	Last Shot	_____
German Measles	☐ No ☐ Yes	Last Shot	_____
Other _____		Last Shot	_____

ALLERGIES: Are you allergic to any of the following?

Penicillin	☐ No ☐ Yes		
Sulfa	☐ No ☐ Yes		
Other Antibiotics	☐ No ☐ Yes	What	_____
Any other Drugs or Medicine	☐ No ☐ Yes	What	_____
Any Foods	☐ No ☐ Yes	What	_____
Nail Polish or Cosmetics	☐ No ☐ Yes	What	_____
Other _____		What	_____

DEVICES: Do you use any of the following devices?

Eyeglasses	☐ No ☐ Yes		
Contact Lenses	☐ No ☐ Yes		
Hearing Aids	☐ No ☐ Yes		
Dentures	☐ No ☐ Yes		
Neck Brace	☐ No ☐ Yes		
Back Brace	☐ No ☐ Yes		
Other Brace	☐ No ☐ Yes	What	_____
Artificial Limb	☐ No ☐ Yes		
Truss	☐ No ☐ Yes		
Pacemaker	☐ No ☐ Yes		
I.U.D.	☐ No ☐ Yes		
Diaphragm	☐ No ☐ Yes		

Other _____

MEDICINES: Are you currently taking any medicines regularly?

☐ No ☐ Yes

If YES, what medicines? _____

_____

_____

Have you ever taken any of these medicines?

Insulin	☐ No ☐ Yes	When	_____
Cortisone	☐ No ☐ Yes	When	_____
Thyroid Medicine	☐ No ☐ Yes	When	_____
Male or Female Hormones	☐ No ☐ Yes	When	_____
Blood Pressure Medicines	☐ No ☐ Yes	When	_____
Tranquilizers or sedatives	☐ No ☐ Yes	When	_____
Birth Control Pills	☐ No ☐ Yes	When	_____
Other _____		When	_____

OPERATIONS: Have you had any of these operated upon?

Tonsils	☐ No ☐ Yes	When	_____
Appendix	☐ No ☐ Yes	When	_____
Gall Bladder	☐ No ☐ Yes	When	_____
Stomach	☐ No ☐ Yes	When	_____
Small Intestine	☐ No ☐ Yes	When	_____
Kidney	☐ No ☐ Yes	When	_____
Colon	☐ No ☐ Yes	When	_____
Thyroid	☐ No ☐ Yes	When	_____
Hernia	☐ No ☐ Yes	When	_____

Other _____

WOMEN:

Breast	☐ No ☐ Yes	When	_____
Ovaries	☐ No ☐ Yes	When	_____
Uterus	☐ No ☐ Yes	When	_____

MEN:

Prostate	☐ No ☐ Yes	When	_____

DIAGNOSED DIFFICULTIES: Do you now or have you in the past, had any of the following?

Migraine Headaches	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Epilepsy or Convulsions	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Stroke	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Glaucoma	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Cataracts	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Blindness in either eye	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Ear Infections	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Deafness	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Asthma	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Hay Fever	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Chronic Bronchitis	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Emphysema	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Tuberculosis	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Abnormal Chest X-Ray	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Heart Murmur as an adult	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Abnormal Electrocardiogram	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Enlarged Heart	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Heart Attack	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Rheumatic Fever	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Angina	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
High Blood Pressure	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Gall Stones	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Hepatitis	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Cirrhosis of Liver	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Stomach or Duodenal Ulcer	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Abnormal Stomach X-Ray	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Colon or Bowel Trouble	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Rectal Trouble	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Hemorrhoids or piles	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Dysentery or serious diarrhea	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Kidney or Bladder Infection	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Kidney Stones	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Other Kidney Disease?	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____

What? _____

Anemia	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____

What kind? _____

Poor Blood Clotting	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____
Gout	☐ No	☐ Yes, Have Now	☐ Yes, In Past	When _____

PATIENT'S PERSONAL HISTORY (continued)

Diabetes ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

On Insulin? ☐ No ☐ Yes

How Much? _____

Overactive Thyroid ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Under active Thyroid ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Goiter ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Broken Bones ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Varicose Veins ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Arthritis ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Polio ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Phlebitis ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Syphilis or V.D. ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Oral or genital herpes ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Gonorrhea ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

HIV/AIDS ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Recurrent Boils ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Other Skin Disease ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

What Kind? _____

Serious Depression ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Serious Emotional Problem ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Nervous Breakdown ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

WOMEN:

Menstrual Difficulties ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Ovarian Cyst ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Other GYN Problems ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

What Kind? _____

Age Periods Started _____

Still Menstruating ☐ No ☐ Yes

Age Periods Stopped _____

Why Periods Stopped _____

Are your periods regular? ☐ No ☐ Yes

Cystitis ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Mastitis ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Breast Cancer ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Other Breast Disease ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

What kind? _____

Number of Children _____ Number of Miscarriages _____ Number of Times Pregnant _____

MEN:

Prostate Trouble ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

Other Illness? ☐ No ☐ Yes, Have Now ☐ Yes, In Past When _____

What Kind? _____

COMPLAINTS: Do you have any of the following complaints?

GENERAL:

Fever	No	Yes
Chills	No	Yes
Aches and Pains	No	Yes
General Headaches	No	Yes
Memory Loss	No	Yes
Swollen Glands	No	Yes
Easy Bruising	No	Yes

HEAD:

Blurred Vision (not corrected)	No	Yes
By glasses	No	Yes
Double Vision	No	Yes
Light Flashes	No	Yes
Halos around lights	No	Yes
Pain in your eyes	No	Yes
Ear Pain	No	Yes
Drainage from ear	No	Yes
Hearing Difficulty or Deafness	No	Yes
Buzzing or Ringing in ears	No	Yes
Nosebleeds (not from injury)	No	Yes
Sinus Trouble	No	Yes
Difficulty swallowing	No	Yes
Mouth, Tooth, or Tongue problem	No	Yes
Persistent Hoarseness	No	Yes
Severe Headaches	No	Yes

Other _____

SKIN:

Changing Mole	No	Yes
Rash	No	Yes
Yellow Skin	No	Yes
Other Skin Problems?	No	Yes

What is it? _____

NECK:

Swelling	No	Yes
Lumps	No	Yes
Stiffness	No	Yes

Other _____

CHEST, HEART, LUNGS:

Shortness of breath	No	Yes
Poor exercise tolerance	No	Yes
Fluttering of Heart	No	Yes
Unusual Heartbeat	No	Yes
Chest Pain or Pressure Attacks	No	Yes
Frequent cough	No	Yes
Coughing up blood	No	Yes
Wheezing	No	Yes
Night sweats	No	Yes
Swollen ankles	No	Yes
Leg cramps	No	Yes

Other _____

GASTROINTESTINAL:

Poor appetite	No	Yes
Indigestion or heartburn	No	Yes
Difficulty swallowing	No	Yes
Nausea or vomiting	No	Yes
Vomiting blood	No	Yes
Abdominal pain or cramps	No	Yes
Abdominal swelling	No	Yes
Diarrhea	No	Yes
Constipation	No	Yes
Change in bowel habits	No	Yes
Pass blood from rectum	No	Yes
Black tar-like bowel movements	No	Yes

Other _____

ENDOCRINE:

Thirsty all the time	No	Yes
Cold most of the time	No	Yes
Too warm most of the time	No	Yes
Unusually tired or sluggish	No	Yes
Unusually jumpy or nervous	No	Yes

Other _____

COMPLAINTS (continued)

NEUROMUSCULAR:

Weakness in arms or legs	☐ No	☐ Yes
Difficulty with balance	☐ No	☐ Yes
Dizzy spells	☐ No	☐ Yes
Fainting spells	☐ No	☐ Yes
Speech difficulty	☐ No	☐ Yes

Other _____

BONE-JOINTS:

Painful Joints	☐ No	☐ Yes
Swollen Joints	☐ No	☐ Yes
Loss of muscle strength	☐ No	☐ Yes
Lump or swelling in muscle	☐ No	☐ Yes
Lump on bone	☐ No	☐ Yes
Back Pain	☐ No	☐ Yes

Other _____

KIDNEY:

Blood in urine	☐ No	☐ Yes
Pain or burning while urinating	☐ No	☐ Yes
Difficulty passing urine	☐ No	☐ Yes
Getting up at night to urinate	☐ No	☐ Yes

Other _____

PSYCHOLOGICAL:

Do you find life:

Generally unsatisfactory	☐ No	☐ Yes
Too demanding	☐ No	☐ Yes
Boring	☐ No	☐ Yes
Satisfactory	☐ No	☐ Yes

Do you worry about:

Money	☐ No	☐ Yes
Job	☐ No	☐ Yes
Marriage	☐ No	☐ Yes
Home Life	☐ No	☐ Yes
Children	☐ No	☐ Yes

Do you:

Cry Easily	☐ No	☐ Yes
Feel inferior to others	☐ No	☐ Yes
Feel shy	☐ No	☐ Yes
Feel things often go wrong	☐ No	☐ Yes
Often feel depressed	☐ No	☐ Yes
Have irrational fears	☐ No	☐ Yes
Feel anxious or upset	☐ No	☐ Yes

Have you:

Seriously considered suicide	☐ No	☐ Yes
Attempted suicide	☐ No	☐ Yes

GENITALIA:

WOMEN:

Breast Lump	☐ No	☐ Yes
Discharge from nipple	☐ No	☐ Yes
Other breast problem	☐ No	☐ Yes

What? _____

Vaginal Discharge	☐ No	☐ Yes
Vaginal bleeding or spotting (not with periods)	☐ No	☐ Yes
Hot Flashes	☐ No	☐ Yes
Pain with intercourse	☐ No	☐ Yes
Possibly Pregnant	☐ No	☐ Yes
Change in Periods	☐ No	☐ Yes
Pain not associated with periods	☐ No	☐ Yes

Other _____

MEN:

Breast Lump	☐ No	☐ Yes
Discharge from penis	☐ No	☐ Yes
Sore on penis	☐ No	☐ Yes
Lump in testicles	☐ No	☐ Yes
Difficulty having erections	☐ No	☐ Yes

Other _____

CHIEF COMPLAINTS: Please complete the sections below for each disease or symptom you are currently experiencing. Beginning with Section 1, list the diseases or symptoms in the order of importance or severity.

1) Symptom or Disease: _____

When did and symptoms start? _____

How often do you experience symptoms? (*Please check one)* ☐ Daily ☐ Every Other Day ☐ 2 - 3 Times a Week ☐ Weekly ☐ Monthly

Other _____

How long do the episodes last? _____

Have you seen another physician regarding this? ☐ Yes ☐ No

If yes, who and what specialty? _____

What tests did you have done? _____

_____

If so, what treatment was prescribed? _____

Please list any medications you have taken for these symptoms/this disease: _____

_____

Have you had any side effects or other problems with these medications? *(ineffective, etc)* ☐ Yes ☐ No

If so, what medication was it and what was the side effect or result from that medication? *(Please list all)* _____

_____

_____

_____

2) Symptom or Disease: _____

When did and symptoms start? _____

How often do you experience symptoms? (*Please check one)* ☐ Daily ☐ Every Other Day ☐ 2 - 3 Times a Week ☐ Weekly ☐ Monthly

Other _____

How long do the episodes last? _____

Have you seen another physician regarding this? ☐ Yes ☐ No

If yes, who and what specialty? _____

What tests did you have done? _____

_____

If so, what treatment was prescribed? _____

Please list any medications you have taken for these symptoms/this disease: _____

_____

Have you had any side effects or other problems with these medications? *(ineffective, etc)* ☐ Yes ☐ No

If so, what medication was it and what was the side effect or result from that medication? *(Please list all)* _____

_____

_____

_____

CHIEF COMPLAINTS (continued)

3) Symptom or Disease: _____

When did and symptoms start? _____

How often do you experience symptoms? (*Please check one)* ☐ Daily ☐ Every Other Day ☐ 2 - 3 Times a Week ☐ Weekly ☐ Monthly

Other _____

How long do the episodes last? _____

Have you seen another physician regarding this? ☐ Yes ☐ No

If yes, who and what specialty? _____

What tests did you have done? _____

_____

If so, what treatment was prescribed? _____

Please list any medications you have taken for these symptoms/this disease: _____

_____

Have you had any side effects or other problems with these medications? *(ineffective, etc)* ☐ Yes ☐ No

If so, what medication was it and what was the side effect or result from that medication? *(Please list all)* _____

_____

_____

_____

4) Symptom or Disease: _____

When did and symptoms start? _____

How often do you experience symptoms? (*Please check one)* ☐ Daily ☐ Every Other Day ☐ 2 - 3 Times a Week ☐ Weekly ☐ Monthly

Other _____

How long do the episodes last? _____

Have you seen another physician regarding this? ☐ Yes ☐ No

If yes, who and what specialty? _____

What tests did you have done? _____

_____

If so, what treatment was prescribed? _____

Please list any medications you have taken for these symptoms/this disease: _____

_____

Have you had any side effects or other problems with these medications? *(ineffective, etc)* ☐ Yes ☐ No

If so, what medication was it and what was the side effect or result from that medication? *(Please list all)* _____

_____

_____

_____

CHIEF COMPLAINTS (continued)

5) Symptom or Disease: _____

When did and symptoms start? _____

How often do you experience symptoms? (*Please check one)* ☐ Daily ☐ Every Other Day ☐ 2 - 3 Times a Week ☐ Weekly ☐ Monthly

Other _____

How long do the episodes last? _____

Have you seen another physician regarding this? ☐ Yes ☐ No

If yes, who and what specialty? _____

What tests did you have done? _____

_____

If so, what treatment was prescribed? _____

Please list any medications you have taken for these symptoms/this disease: _____

_____

Have you had any side effects or other problems with these medications? *(ineffective, etc)* ☐ Yes ☐ No

If so, what medication was it and what was the side effect or result from that medication? *(Please list all)* _____

_____

_____

_____

6) Symptom or Disease: _____

When did and symptoms start? _____

How often do you experience symptoms? (*Please check one)* ☐ Daily ☐ Every Other Day ☐ 2 - 3 Times a Week ☐ Weekly ☐ Monthly

Other _____

How long do the episodes last? _____

Have you seen another physician regarding this? ☐ Yes ☐ No

If yes, who and what specialty? _____

What tests did you have done? _____

_____

If so, what treatment was prescribed? _____

Please list any medications you have taken for these symptoms/this disease: _____

_____

Have you had any side effects or other problems with these medications? *(ineffective, etc)* ☐ Yes ☐ No

If so, what medication was it and what was the side effect or result from that medication? *(Please list all)* _____

_____

_____

_____

GENERAL QUESTIONAIRE

HOME

1. What is your living situation? *(Who lives in your home with you? Married? etc)* _____

   a) Do you have any family stressors? ☐ Yes

   If so, please describe the stressor(s): _____

   b) On a scale of 0 - 10, (0 being No Stress, and 10 being Extremely Stressful), how would you rate your level of stress at home? _____

2. Have you ever smoked? ☐ Yes ☐ No

   a) If so, how many years? *(or age started and/or stopped)* _____

   b) How many packs per day? _____

   c) Did one or both of your parents smoke when you were living in their home? ☐ Yes ☐ No

3. Do you have any pets? ☐ Yes ☐ No

   a) If so, are they Indoors or Outdoors? ☐ Indoors ☐ Outdoors

   b) How many do you have? _____

   c) What kind of pets do you have? _____

4. What *time do you to bed most nights?* _____ What *time do you wake up?* _____

   a) Do you have problems falling asleep? ☐ Yes ☐ No

   b) Do you have problems staying asleep? ☐ Yes ☐ No

   c) Approximately how many time do you wake during the night? _____

   d) Are you able to immediately fall back to sleep? ☐ Yes ☐ No

   e) Do you feel rested upon waking? ☐ Yes ☐ No

   f) Do you snore? ☐ Yes ☐ No

5. Do you do any of the following close to the time you try to sleep?

   a) Drink caffeinated beverages? ☐ Yes ☐ No

   b) Watch T.V. in your bed? ☐ Yes ☐ No

   c) Exercise near the time you go to bed? ☐ Yes ☐ No

WORK

1. What kind of work do you do? _____

   a) Do you enjoy your work? ☐ Yes ☐ No

   b) On a scale of 0 - 10, (0 being No Stress, and 10 being Extremely Stressful), how would you rate your level of stress at work? _____

2. Does your work involve exposure to chemicals or radiation? ☐ Yes ☐ No

   a) If so, what type of chemical or radiation? _____

   b) How long have you been exposed to these chemicals? *(months, years, etc)* _____

   c) If you were exposed in the past, please describe the type of exposure and how long you were exposed _____

   _____

MEDICAL HISTORY

1. Have you ever had any type of surgery? ☐ Yes ☐ No

If so, what was the surgery? *(List all surgeries you have ever had and approximately how old you were, or the year you had them)* _____

_____

_____

2. Have you ever been hospitalized for anything (other than surgery) overnight? ☐ Yes ☐ No

If so, what were you hospitalized for? *(Please list all occurrences)* _____

_____

3. How many amalgams (silver fillings) have you ever had in your life? _____

4. Have you had all childhood immunizations? ☐ Yes ☐ No

If so, which immunizations haven't you had? _____

5. Do you receive regular flu and pneumonia immunizations? ☐ Yes ☐ No

6. Do you give blood? ☐ Yes ☐ No

If so, how often do you give? _____

7. Have you ever received a transfusion? ☐ Yes ☐ No

If so, when did you receive the transfusion? _____

8. Have you ever undergone fertility treatments? ☐ Yes ☐ No

a) If so, what were the treatments? _____

b) When did the treatments start? _____

c) When did the treatments end? _____

9. Do you use any over the counter medications? ☐ Yes ☐ No

a) If so, what kind of medications do you use? _____

b) How much do you take of these (dosage)? _____

c) How often do you use these medications? _____

10. Do you have daily bowel movements? ☐ Yes ☐ No

a) If so, what is the character of these? (*Please check one)* ☐ Hard ☐ Firm ☐ Soft but formed ☐ Soft but unformed ☐ Loose

b) If not, how often do you go? (*Please check one)* ☐ Every other day ☐ Every 2 days ☐ Every 3 days ☐ Every 4 days

☐ Every 5 days ☐ Every 6 days ☐ Every 7 days

CHEMICAL AND ENVIRONMENTAL EXPOSURE

1. Do you have reactions to chemicals or perfumes? ☐ Yes ☐ No

   a) If so, what chemical or perfume? _____

   b) What type of reaction occurs? _____

   c) How long does the reaction last? _____

2. Do you use any pesticides in your home or lawn? ☐ Yes ☐ No

   a) If so, where do you use them? _____

   b) How often do you use them? _____

3. Have you been exposed to chemicals or other environmental substances at work? ☐ Yes ☐ No

   If so, what kind of substances were you exposed to? *(examples: paint, solvents, radiation, asbestos, manufacturing chemicals, hairstyling chemicals, etc)*

   _____

   _____

4. Have you been exposed to chemicals or other environmental substances at home? ☐ Yes ☐ No

   a) If so, what kind of substances were you exposed to? *(examples: household cleaners, solvents, poisons, outgassing from new carpet or paint, carpet cleaners, etc)*

   _____

   _____

   b) Do you live (or have you ever lived) near a chemical waste site (a superfund site), nuclear power plant, chemical manufacturing plant, etc? ☐ Yes ☐ No

   If so, describe the kind of site you live(d) near: _____

   _____

5. Do you have any hobbies that include the use of chemicals? ☐ Yes ☐ No

   If so, what are your hobbies and what chemicals or substances are involved? *(examples: paints, varnish, paint strippers, glue, etc)* _____

   _____

6. Do you have any tattoos? ☐ Yes ☐ No

   If so, how many, when did you get them, how long have you had them, and where are they located? _____

   _____

7. Do you have any piercings? ☐ Yes ☐ No

   If so, how many, when did you get them, how long have you had them, and where are they located? _____

   _____

MENSTRUAL HISTORY

(women only)

Name _____ Date _____

What age did your period start? _____

What were your periods like as a teenager and into your 20's? Heavy? ☐ Yes ☐ No Any clots at all (even if not heavy)? ☐ Yes ☐ No

Length of cycle: Every _____ days, lasting _____ days.

Pain? ☐ Yes ☐ No

On a scale of 0 - 10, (0 being No Pain, and 10 being Extremely Painful), how would you rate your level of pain? _____

Did you ever have to miss school or work? ☐ Yes ☐ No

What are your periods like now, or if not having periods what were they like just before they stopped?

Heavy? ☐ Yes ☐ No

Any clots at all (even if not heavy)? ☐ Yes ☐ No

Length of cycle: Every _____ days, lasting _____ days.

Pain? ☐ Yes ☐ No

On a scale of 0 - 10, (0 being No Pain, and 10 being Extremely Painful), how would you rate your level of pain? _____

Did you ever have to miss school or work? ☐ Yes ☐ No

How many days (or weeks) before your period do/did you know you're having your period? _____

Any signs or symptoms at all? Such as:

Bloating	☐ Yes	☐ No	Weepiness	☐ Yes	☐ No
Water weight gain	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Headache	☐ Yes	☐ No	Breast Tenderness	☐ Yes	☐ No
Irritability/Moodiness	☐ Yes	☐ No	Back Pain	☐ Yes	☐ No

Have you ever been pregnant? ☐ Yes ☐ No

If so, how many times? _____

How many live births? _____

How many miscarriages? _____

Did/do you have problems getting pregnant? ☐ Yes ☐ No

If so, please describe the problem as you understand it: _____

_____

If you have ever been pregnant, how did you feel during pregnancy? And during which trimester did you feel the best? _____

_____

_____

_____

_____

MENOPAUSE

If you are menopausal, at what age did your periods stop completely? _____

At what age did your periods start to slow down or show other signs of change? _____

Did you have a Hysterectomy? ☐ Yes ☐ No

If so, what kind? Total Abdominal Hysterectomy? ☐ Yes ☐ No Partial Hysterectomy (only the Uterus) ☐ Yes ☐ No

If so, why did you have a Hysterectomy?

Heavy Bleeding? ☐ Yes ☐ No Fibroid Uterus? ☐ Yes ☐ No

Endometriosis? ☐ Yes ☐ No Cancer? ☐ Yes ☐ No Precancer? ☐ Yes ☐ No

When you became menopausal what symptoms did you have?

Hot Flashes? ☐ Yes ☐ No Vaginal Dryness? ☐ Yes ☐ No Decreased Memory/Concentration? ☐ Yes ☐ No

Poor Sleep? ☐ Yes ☐ No Dry Skin or Mouth? ☐ Yes ☐ No Increased Aches and Pains? ☐ Yes ☐ No

Moodiness? ☐ Yes ☐ No

Have you taken any medications for menopause? ☐ Yes ☐ No

Any hormone replacement? ☐ Yes ☐ No

If so, what kind? _____

If so, when and for how long? Start _____ End _____

Or are you Currently? ☐ Yes ☐ No

Did these hormones alleviate all of the above symptoms? ☐ Yes ☐ No

If not all, then which symptoms do/did you still have while taking the hormones? _____

_____

While on hormone replacement therapy, did you have any breast, cervical, or uterine biopsies ☐ Yes ☐ No
or abnormalities of your mammogram or any other tests?

If so, please describe the occurrence and the year when it happened: _____

_____

What menopausal symptoms do you have now?

Hot Flashes? ☐ Yes ☐ No Vaginal Dryness? ☐ Yes ☐ No Decreased Memory/Concentration? ☐ Yes ☐ No

Poor Sleep? ☐ Yes ☐ No Dry Skin or Mouth? ☐ Yes ☐ No Increased Aches and Pains? ☐ Yes ☐ No

Moodiness? ☐ Yes ☐ No Other Symptoms: _____

Has any first-degree relative (mother, sister) had breast cancer, uterine cancer, or cervical cancer? ☐ Yes ☐ No

If yes, please list whom, what kind, and the age these occurred: _____

Has any second-degree relative (aunt, cousin, grandparent) had breast cancer, uterine cancer, or cervical cancer? ☐ Yes ☐ No

If yes, please list whom, what kind, and the age these occurred: _____

HEALTH APPRAISAL QUESTIONAIRE

Name _____ Date _____

PART 1: *Please check any of the following medications you are currently taking:*

Antacids	☐ Yes	☐ No	Cortisone	☐ Yes	☐ No	Lithium	☐ Yes	☐ No
Antibiotics/Antifungal	☐ Yes	☐ No	Anti-Inflammatories	☐ Yes	☐ No	Oral Contraceptives	☐ Yes	☐ No
Antidepressants	☐ Yes	☐ No	Heart Medications	☐ Yes	☐ No	Radiation	☐ Yes	☐ No
Antidiabetic/Insulin	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Relaxants/ Sleeping pills	☐ Yes	☐ No
Aspirin/Tylenol	☐ Yes	☐ No	Hormones	☐ Yes	☐ No	Ulcer	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Laxatives	☐ Yes	☐ No	Recreational Drugs	☐ Yes	☐ No

Thyroid: _____ Other: _____

Please check any of the following if you eat, drink, or use:

Alcohol	☐ Yes	☐ No	Coffee	☐ Yes	☐ No	Margarine	☐ Yes	☐ No
Candy	☐ Yes	☐ No	Distilled Water	☐ Yes	☐ No	Refined Sugars	☐ Yes	☐ No
Carbonated Beverages	☐ Yes	☐ No	Fried Foods	☐ Yes	☐ No	Saccharine (sweet & low)	☐ Yes	☐ No
Cigarettes	☐ Yes	☐ No	Luncheon Meats	☐ Yes	☐ No	Chewing Tobacco	☐ Yes	☐ No

Vitamins and/or Minerals (please list): _____

_____

_____

Please check any that apply to you:

Diet Often	☐ Yes	☐ No	Salt Food without Tasting	☐ Yes	☐ No	Exposed to Chemicals at Work	☐ Yes	☐ No
Do Not Exercise	☐ Yes	☐ No	Under Excessive Stress	☐ Yes	☐ No	Exposed to Cigarette Smoke	☐ Yes	☐ No

PART 2: *Please check the number that best describe the intensity of your symptoms. If you do not know the answer to a question, leave it blank.*

0 = Symptom Not Present 1= Mild 2= Moderate 3= Severe

SECTION A:	0	1	2	3	SECTION B:	0	1	2	3
1. Burping	☐	☐	☐	☐	1. Abdominal cramps	☐	☐	☐	☐
2. Fullness for extended time after meals	☐	☐	☐	☐	2. Indigestion 1-3 hours after eating	☐	☐	☐	☐
3. Bloating	☐	☐	☐	☐	3. Fatigue after eating	☐	☐	☐	☐
4. Poor appetite	☐	☐	☐	☐	4. Lower-bowel gas	☐	☐	☐	☐
5. Stomach upsets easily	☐	☐	☐	☐	5. Alternating constipation & diarrhea	☐	☐	☐	☐
6. History of constipation	☐	☐	☐	☐	6. Diarrhea	☐	☐	☐	☐
7. Known food allergies	☐	☐	☐	☐	7. Roughage & fiber causes constipation	☐	☐	☐	☐

SECTION B: (continued)	0	1	2	3
8. Mucous in stools	☐	☐	☐	☐
9. Stool poorly formed	☐	☐	☐	☐
10. Shiny stool	☐	☐	☐	☐
11. Three + large bowel movements daily	☐	☐	☐	☐
12. Foul smelling stool	☐	☐	☐	☐
13. Dry skin and/or brittle hair	☐	☐	☐	☐
14. Pain in left side under rib cage	☐	☐	☐	☐
15. Acne	☐	☐	☐	☐
16. Food allergies	☐	☐	☐	☐

SECTION C:	0	1	2	3
1. Stomach pain	☐	☐	☐	☐
2. Stomach pain just before/after meals	☐	☐	☐	☐
3. Dependency on antacids	☐	☐	☐	☐
4. Chronic abdominal pain	☐	☐	☐	☐
5. Butterfly sensations in stomach	☐	☐	☐	☐
6. Difficulty belching	☐	☐	☐	☐
7. Stomach pain when emotionally upset	☐	☐	☐	☐
8. Sudden, acute indigestion	☐	☐	☐	☐
9. Relief of symptoms by carbonation	☐	☐	☐	☐
10. Relief of symptoms with cream/milk	☐	☐	☐	☐
11. History of ulcers or gastritis	☐	☐	☐	☐
12. Current ulcer	☐	☐	☐	☐
13. Black stool when not taking Iron	☐	☐	☐	☐

SECTION D:	0	1	2	3
1. Seasonal diarrhea	☐	☐	☐	☐
2. Frequent and current infections/colds	☐	☐	☐	☐
3. Bladder and kidney infections	☐	☐	☐	☐
4. Vaginal yeast infections	☐	☐	☐	☐
5. Abdominal cramps	☐	☐	☐	☐
6. Toe and fingernail fungus	☐	☐	☐	☐
7. Alternating constipation and diarrhea	☐	☐	☐	☐
8. Constipation	☐	☐	☐	☐
9. History of antibiotic use	☐	☐	☐	☐
10. Meat eater	☐	☐	☐	☐
11. Rapidly failing vision	☐	☐	☐	☐

PART 3: *Continue through parts 3 - 13. Some questions are repeated. Answer each question. (Females skip part 9, Males skip part 10)*

SECTION A:	0	1	2	3
1. Intolerance to greasy food	☐	☐	☐	☐
2. Headaches after eating	☐	☐	☐	☐
3. Light-colored stool	☐	☐	☐	☐
4. Foul-smelling stool	☐	☐	☐	☐
5. Less than one bowel movement daily	☐	☐	☐	☐
6. Constipation	☐	☐	☐	☐
7. Hard Stool	☐	☐	☐	☐
8. Sour taste in mouth	☐	☐	☐	☐
9. Grey-colored skin	☐	☐	☐	☐
10. Yellow in whites of eyes	☐	☐	☐	☐
11. Bad breath	☐	☐	☐	☐
12. Body odor	☐	☐	☐	☐
13. Fatigue and sleepiness after eating	☐	☐	☐	☐
14. Pain in right side under rib cage	☐	☐	☐	☐
15. Painful to pass stool	☐	☐	☐	☐
16. Retain water	☐	☐	☐	☐
17. Big toe painful	☐	☐	☐	☐
18. Pain radiates along outside of leg	☐	☐	☐	☐
19. Dry skin/hair	☐	☐	☐	☐
20. Red blood in stool	☐	☐	☐	☐
21. Have had jaundice or hepatitis	☐	☐	☐	☐
22. High blood pressure/low HDL chol.	☐	☐	☐	☐
23. Cholesterol level above 215	☐	☐	☐	☐
24. Triglyceride level above 115	☐	☐	☐	☐

SECTION B:	0	1	2	3
1. Swollen eyes	☐	☐	☐	☐
2. Strong-smelling urine	☐	☐	☐	☐
3. Thick skin & fingernails	☐	☐	☐	☐
4. Dry skin	☐	☐	☐	☐
5. Sensitive to the cold	☐	☐	☐	☐
6. Cold hands and feet.	☐	☐	☐	☐
7. Excessive menstrual bleeding	☐	☐	☐	☐
8. Chronic fatigue	☐	☐	☐	☐
9. Trouble waking up in the morning	☐	☐	☐	☐
10. Depressed/Apathetic	☐	☐	☐	☐
11. Low sex drive	☐	☐	☐	☐
12. Puffy or wrinkly skin	☐	☐	☐	☐
13. Irritability caused by sugar	☐	☐	☐	☐
14. Premenstrual tension	☐	☐	☐	☐

SECTION B: (continued)

	0	1	2	3
15. Constipation	☐	☐	☐	☐
16. Thinning/loss of outer part of eyebrow	☐	☐	☐	☐
17. Gain weight easily	☐	☐	☐	☐
18. Anemia unaffected by Iron	☐	☐	☐	☐
19. Armpit temperature below 97.6F	☐	☐	☐	☐
20. Slow reflexes	☐	☐	☐	☐
21. Infertility	☐	☐	☐	☐

PART 4:

SECTION A:

	0	1	2	3
1. Sensitive to exhaust, smoke, and smog	☐	☐	☐	☐
2. Periodic constipation	☐	☐	☐	☐
3. Intolerant of exercise	☐	☐	☐	☐
4. Depression or rapid mood swings	☐	☐	☐	☐
5. Dark circles under eyes	☐	☐	☐	☐
6. Dizziness upon standing	☐	☐	☐	☐
7. Lack of mental alertness	☐	☐	☐	☐
8. Catch colds when weather changes	☐	☐	☐	☐
9. Difficulty breathing	☐	☐	☐	☐
10. Water retention	☐	☐	☐	☐
11. Eyes sensitive to bright light	☐	☐	☐	☐
12. Feel weak & shaky	☐	☐	☐	☐

SECTION B:

	0	1	2	3
1. Inflamed or bleeding gums	☐	☐	☐	☐
2. Runny nose	☐	☐	☐	☐
3. Get boils or styes	☐	☐	☐	☐
4. Nose bleeds	☐	☐	☐	☐
5. Loss of smell	☐	☐	☐	☐
6. Throat infections	☐	☐	☐	☐
7. Cold sores/fever blisters	☐	☐	☐	☐
8. Loss of taste	☐	☐	☐	☐
9. Poor wound healing	☐	☐	☐	☐
10. Hair falls out	☐	☐	☐	☐
11. Swollen lymph glands	☐	☐	☐	☐
12. Ear infections	☐	☐	☐	☐
13. Hair grows slowly	☐	☐	☐	☐
14. Slow to recover from colds or flu	☐	☐	☐	☐
15. Catch colds or flu easily	☐	☐	☐	☐
16. Bumpy skin on backs of arms	☐	☐	☐	☐

SECTION C:

	0	1	2	3
1. Eczema and psoriasis	☐	☐	☐	☐
2. Asthma/Bronchitis	☐	☐	☐	☐
3. Migraine headaches	☐	☐	☐	☐
4. Entire body aches, painful to touch	☐	☐	☐	☐
5. Swollen joints	☐	☐	☐	☐
6. Food sensitivities or allergies	☐	☐	☐	☐
7. Feel sick, depressed from certain foods	☐	☐	☐	☐
8. Chronic pain	☐	☐	☐	☐
9. Painful stomach/intestines	☐	☐	☐	☐
10. Alternating constipation and diarrhea	☐	☐	☐	☐
11. Mucous in throat	☐	☐	☐	☐
12. Post-nasal drip	☐	☐	☐	☐
13. Discharge from eyes	☐	☐	☐	☐
14. Itchy eyes	☐	☐	☐	☐
15. Puffiness/dark circles under eyes	☐	☐	☐	☐
16. Ear discharge or stuffy ears	☐	☐	☐	☐
17. Sinusitis or rhinitis	☐	☐	☐	☐
18. Runny nose	☐	☐	☐	☐
19. Breathe through mouth	☐	☐	☐	☐
20. Swollen tongue	☐	☐	☐	☐
21. Difficulty swallowing	☐	☐	☐	☐
22. Bedwetting	☐	☐	☐	☐
23. Hyperactivity	☐	☐	☐	☐
24. Chronic lung congestion	☐ No	☐ Yes		
25. Use aspirin or Tylenol regularly	☐ No	☐ Yes		
26. Use cortisone or prednisone	☐ No	☐ Yes		
27. Total hair loss (Alopecia)	☐ No	☐ Yes		

PART 5:

SECTION A:	0	1	2	3
1. Shortness of breath	☐	☐	☐	☐
2. Chest pain while walking	☐	☐	☐	☐
3. Heaviness in legs	☐	☐	☐	☐
4. Calf muscles cramp while walking	☐	☐	☐	☐
5. Heart pound easily	☐	☐	☐	☐
6. Feel jittery	☐	☐	☐	☐
7. Heart misses beats or has extra beats	☐	☐	☐	☐
8. Swelling of feet and ankles	☐	☐	☐	☐
9. Rapidly beating heart	☐	☐	☐	☐
10. Heartburn after eating	☐	☐	☐	☐
11. Pain in left arm	☐	☐	☐	☐
12. Exhausted after minor exertion	☐	☐	☐	☐
13. Do you do aerobic exercise?	☐ No	☐ Yes		
14. Have you ever exercised regularly?	☐ No	☐ Yes		
15. Bright red nose	☐ No	☐ Yes		
16. At rest, heart beats per minute (leave blank if under 80 BPM)	☐ 80-90	☐ 90+		

SECTION B:	0	1	2	3
1. Cold hands and feet	☐	☐	☐	☐
2. Slurred speech	☐	☐	☐	☐
3. Calf muscles cramp while walking	☐	☐	☐	☐
4. Headaches	☐	☐	☐	☐
5. Numbness in extremities	☐	☐	☐	☐
6. Poor concentration	☐	☐	☐	☐
7. Ringing in ears	☐	☐	☐	☐
8. Ear canal hair	☐ No	☐ Yes		
9. Heart attack	☐ No	☐ Yes		
10. Stroke	☐ No	☐ Yes		
11. Vertical wrinkle in lower ear lobe	☐ No	☐ Yes		

SECTION C:	0	1	2	3
1. Pain in morning in back of head/neck	☐	☐	☐	☐
2. Dizziness	☐	☐	☐	☐
3. Vertigo	☐	☐	☐	☐
4. Fatigue easily	☐	☐	☐	☐
5. Blushing with no apparent cause	☐	☐	☐	☐
6. Is your blood pressure high?	☐ No	☐ Yes		

PART 6:

SECTION A:	0	1	2	3
1. Dizziness when standing suddenly	☐	☐	☐	☐
2. Loss of vision when standing suddenly	☐	☐	☐	☐
3. Crave sweets	☐	☐	☐	☐
4. Headaches eased by sweets/alcohol	☐	☐	☐	☐
5. Feel shaky	☐	☐	☐	☐
6. Irritable if a meal is missed	☐	☐	☐	☐
7. Wake up in night craving sweets	☐	☐	☐	☐
8. Feel tired or weak if a meal is missed	☐	☐	☐	☐
9. Heart palpitations after eating sweets	☐	☐	☐	☐
10. Need to drink coffee to get started	☐	☐	☐	☐
11. Impatient, moody, nervous	☐	☐	☐	☐
12. Feel tired 1-2 hours after eating	☐	☐	☐	☐
13. Poor memory	☐	☐	☐	☐
14. Poor concentration	☐	☐	☐	☐
15. Forgetful	☐	☐	☐	☐
16. Calmer after eating	☐ No	☐ Yes		

SECTION B:	0	1	2	3
1. Night sweats	☐	☐	☐	☐
2. Increased thirst	☐	☐	☐	☐
3. Lowered resistance to infection	☐	☐	☐	☐
4. Fatigue	☐	☐	☐	☐
5. Boils and leg sores	☐	☐	☐	☐
6. Lesion/cut that takes a long time to heal	☐	☐	☐	☐
7. Overweight	☐	☐	☐	☐
8. Feel pick-up from exercise	☐	☐	☐	☐
9. Failing eyesight	☐	☐	☐	☐
10. Crave sweets, but eating sweets does not relieve the craving	☐	☐	☐	☐
11. Family history of diabetes	☐	☐	☐	☐
12. Sugar in urine	☐	☐	☐	☐

PART 7:

SECTION A: 0 1 2 3

1. Chest pain ☐ ☐ ☐ ☐
2. Chronic cough ☐ ☐ ☐ ☐
3. Difficulty breathing ☐ ☐ ☐ ☐
4. Coughing up blood ☐ ☐ ☐ ☐
5. Coughing up phlegm ☐ ☐ ☐ ☐
6. Pain around ribs ☐ ☐ ☐ ☐
7. Shortness of breath ☐ ☐ ☐ ☐
8. Rattling mucous when you breathe ☐ ☐ ☐ ☐
9. Sensitive to smog ☐ ☐ ☐ ☐
10. Infections settle in lungs ☐ ☐ ☐ ☐
11. Work around people who smoke ☐ ☐ ☐ ☐
12. Bronchitis ☐ ☐ ☐ ☐
13. Exposed to chemicals & radiation ☐ No ☐ Yes
14. Do you smoke? ☐ No ☐ Yes

What do you smoke? _____

Amount per day: _____

PART 8:

SECTION A: 0 1 2 3

1. Frequent urination ☐ ☐ ☐ ☐
2. Frequent bladder infections ☐ ☐ ☐ ☐
3. Rarely need to urinate ☐ ☐ ☐ ☐
4. Urination when you cough or sneeze ☐ ☐ ☐ ☐
5. Painful/burns when you urinate ☐ ☐ ☐ ☐
6. Difficulty passing urine ☐ ☐ ☐ ☐
7. Dripping after urination ☐ ☐ ☐ ☐
8. Can't hold urine ☐ ☐ ☐ ☐
9. Rose-colored/bloody urine ☐ ☐ ☐ ☐
10. Cloudy urine ☐ ☐ ☐ ☐
11. Strong-smelling urine ☐ ☐ ☐ ☐
12. Back/leg pains associated with dripping after urination ☐ ☐ ☐ ☐
13. History of bladder infections ☐ No ☐ Yes
14. Have you used antibiotics to control urinary tract infections? ☐ No ☐ Yes

if yes, when were they last used? _____

Treatment duration: _____

PART 9: *(Males only)*

SECTION A: 0 1 2 3

1. Difficulty urinating ☐ ☐ ☐ ☐
2. A sense of bladder fullness ☐ ☐ ☐ ☐
3. Increasing straining with smaller and smaller amounts of urine passing ☐ ☐ ☐ ☐
4. Rose-colored/bloody urine ☐ ☐ ☐ ☐
5. Painful/burns when you urinate ☐ ☐ ☐ ☐
6. Wake up at night to urinate ☐ ☐ ☐ ☐
7. Dripping after urination ☐ ☐ ☐ ☐
8. Pain or fatigue in legs or back ☐ ☐ ☐ ☐
9. Lack of sex drive ☐ ☐ ☐ ☐
10. Painful ejaculation ☐ ☐ ☐ ☐

SECTION B: 0 1 2 3

1. Difficulty attaining/maintaining erection ☐ ☐ ☐ ☐
2. Anxiety/fear of sexual intimacy ☐ ☐ ☐ ☐
3. Premature ejaculation ☐ ☐ ☐ ☐
4. Pain/coldness in genital area ☐ ☐ ☐ ☐
5. Infertile ☐ No ☐ Yes
6. Varicose veins on scrotum ☐ No ☐ Yes
7. Low sperm count ☐ No ☐ Yes

SECTION C: 0 1 2 3

1. Discharge from penis ☐ ☐ ☐ ☐
2. Past or present rash on penis ☐ ☐ ☐ ☐
3. Swollen genitals ☐ ☐ ☐ ☐
4. Swelling in groin ☐ ☐ ☐ ☐
5. Venereal disease (gonorrhea, syphilis Herpes, or other) ☐ No ☐ Yes

Have now? _____

Have had in past? _____

PART 10: *(Females only)*

SECTION A: 0 1 2 3

Check if you experience any of these symptoms within approximately two weeks (ovulation) prior to menstruation. *(this section only)*

1. Monthly weight gain ☐ ☐ ☐ ☐
2. Moodiness/Irritability ☐ ☐ ☐ ☐
3. Bloating and swelling ☐ ☐ ☐ ☐
4. Nausea/vomiting ☐ ☐ ☐ ☐
5. Suicidal feeling ☐ ☐ ☐ ☐
6. Anxiety ☐ ☐ ☐ ☐
7. Leg cramps and tenderness ☐ ☐ ☐ ☐
8. Asthma attacks ☐ ☐ ☐ ☐
9. Headaches ☐ ☐ ☐ ☐
10. Easily distracted ☐ ☐ ☐ ☐
11. Anger ☐ ☐ ☐ ☐
12. Tender breasts ☐ ☐ ☐ ☐
13. Lower-back aches ☐ ☐ ☐ ☐

Other: _____

SECTION B: 0 1 2 3

1. Vaginal itching ☐ ☐ ☐ ☐
2. Vaginal discharge ☐ ☐ ☐ ☐
3. Little or no desire for sex ☐ ☐ ☐ ☐
4. Dislike for intercourse ☐ ☐ ☐ ☐
5. Missed periods ☐ No ☐ Yes
6. Over 15 years of age and have not began menstruation. ☐ No ☐ Yes
7. Unable to get pregnant ☐ No ☐ Yes
8. Miscarriages ☐ No ☐ Yes
   How many?_____
9. Abortions ☐ No ☐ Yes
   How many?_____

SECTION C: 0 1 2 3

Check if you experience any of these symptoms during menstruation. (*this section only)*

1. Low abdominal pain ☐ ☐ ☐ ☐
2. Dull ache radiating to low back/legs ☐ ☐ ☐ ☐
3. Increased urinary frequency ☐ ☐ ☐ ☐
4. Pelvic soreness ☐ ☐ ☐ ☐
5. Diarrhea ☐ ☐ ☐ ☐
6. Headaches ☐ ☐ ☐ ☐
7. Abdominal bloating ☐ ☐ ☐ ☐
8. Menstrual pain ☐ ☐ ☐ ☐
9. Nausea/vomiting ☐ ☐ ☐ ☐
10. Have to lie down first day or two ☐ ☐ ☐ ☐
11. Craving for sweets ☐ ☐ ☐ ☐
12. Insomnia ☐ ☐ ☐ ☐
13. Light scanty blood flow ☐ ☐ ☐ ☐
14. Pain and cramps without blood flow ☐ ☐ ☐ ☐
15. Heavy menstrual bleeding ☐ ☐ ☐ ☐
16. Anxiety about menstrual cycle ☐ ☐ ☐ ☐
17. Menstrual pain getting worse with time ☐ ☐ ☐ ☐

SECTION D: 0 1 2 3

1. Vaginal bumps and sores ☐ ☐ ☐ ☐
2. Pubic area sore ☐ ☐ ☐ ☐
3. Ovarian cysts ☐ ☐ ☐ ☐
4. Uterine Cysts ☐ ☐ ☐ ☐
5. Pain in ovaries ☐ ☐ ☐ ☐
6. Breast lumps ☐ ☐ ☐ ☐
7. Breasts sore to touch ☐ ☐ ☐ ☐
8. Breasts painful ☐ ☐ ☐ ☐
9. Water retention ☐ ☐ ☐ ☐
10. Swollen feeling ☐ ☐ ☐ ☐
11. Premenstrual breast pain/discomfort ☐ ☐ ☐ ☐
12. Mother used DES while pregnant ☐ No ☐ Yes
13. Recent pap smear positive ☐ No ☐ Yes
14. Family history of breast cancer ☐ No ☐ Yes
15. Form of birth control:
    ☐ None ☐ Pill ☐ IUD ☐ Sponge
    ☐ Diaphragm ☐ Foam ☐ Other

PART 10: ***(continued, Females only)***

SECTION E:

	0	1	2	3
1. Hot flashes	☐	☐	☐	☐
2. Night sweats	☐	☐	☐	☐
3. Hysterectomy	☐ No	☐ Yes		
4. Depression/Mood Swings	☐	☐	☐	☐
5. Insomnia	☐	☐	☐	☐
6. Craving Sweets	☐	☐	☐	☐
7. Heavy bleeding two weeks/month	☐	☐	☐	☐
8. Sweating throughout day	☐	☐	☐	☐
9. Dry skin, hair, and vagina	☐	☐	☐	☐
10. Painful intercourse	☐	☐	☐	☐
11. Vaginal Pain	☐	☐	☐	☐
12. Vaginal Itching	☐	☐	☐	☐
13. Osteoporosis (bone loss)	☐ No	☐ Yes		

PART 11:

SECTION A:

	0	1	2	3
1. Pain in fingers	☐	☐	☐	☐
2. Bones sore/painful	☐	☐	☐	☐
3. Eat Meat	☐	☐	☐	☐
4. Cavities	☐	☐	☐	☐
5. Arthritis	☐	☐	☐	☐
6. Drink carbonated beverages OZ/week _____	☐ No	☐ Yes		
7. Gum disease	☐ No	☐ Yes		
8. Bone loss	☐ No	☐ Yes		
9. Calcium deposits	☐ No	☐ Yes		
10. Use antacids	☐ No	☐ Yes		
11. Dentures	☐ No	☐ Yes		
12. Bone deformity	☐ No	☐ Yes		
13. Osteoporosis/Osteomalacia	☐ No	☐ Yes		
14. Recent bone fracture	☐ No	☐ Yes		
15. Post-menopausal	☐ No	☐ Yes		

SECTION B:

	0	1	2	3
1. Muscle spasms	☐	☐	☐	☐
2. Tightness in shoulder muscles	☐	☐	☐	☐
3. Muscle cramps	☐	☐	☐	☐
4. Pain in arms and hands	☐	☐	☐	☐
5. Leg cramps at night	☐	☐	☐	☐
6. Stiff all over	☐	☐	☐	☐
7. Stiff in moving	☐	☐	☐	☐
8. Unable to sit straight	☐	☐	☐	☐
9. Pain in neck and shoulders	☐	☐	☐	☐

SECTION C:

	0	1	2	3
1. Over flexible joints (double-jointed)	☐	☐	☐	☐
2. Back Pain	☐	☐	☐	☐
3. Swollen knees/elbows	☐	☐	☐	☐
4. Athletic injury	☐	☐	☐	☐
5. Bursitis	☐	☐	☐	☐
6. Tendonitis	☐	☐	☐	☐
7. Joint pain	☐	☐	☐	☐
8. Slipped disc	☐ No	☐ Yes		
9. Herniated disc	☐ No	☐ Yes		
10. Loss in height	☐ No	☐ Yes		
11. Injure easily	☐ No	☐ Yes		

PART 12:

SECTION A:

	0	1	2	3
1. Head feels heavy	☐	☐	☐	☐
2. Light-headedness/fainting	☐	☐	☐	☐
3. Loss of balance	☐	☐	☐	☐
4. Dizziness	☐	☐	☐	☐
5. Ringing/buzzing in ears	☐	☐	☐	☐
6. Trembling hands	☐	☐	☐	☐
7. Loss of feeling in hands/feet	☐	☐	☐	☐
8. Exhaustion after slightest effort	☐	☐	☐	☐
9. Limbs feel too heavy to hold up	☐	☐	☐	☐
10. Loss of grip strength	☐	☐	☐	☐
11. Tingling pain sensation	☐	☐	☐	☐
12. Convulsions	☐	☐	☐	☐
13. Incoordination	☐	☐	☐	☐
14. Nervousness	☐	☐	☐	☐
15. Accident prone	☐	☐	☐	☐
16. Loss of muscle tone	☐	☐	☐	☐
17. Need to sleep 10-12 hours	☐	☐	☐	☐
18. Have had shingles	☐	☐	☐	☐

PART 13:

SECTION A:	0	1	2	3
1. Nightmares	☐	☐	☐	☐
2. Can't fall asleep	☐	☐	☐	☐
3. Intense dreams	☐	☐	☐	☐
4. Leg cramps/restless legs at night	☐	☐	☐	☐
5. Restless, uneasy sleep	☐	☐	☐	☐

6. Awake frequently throughout night ☐ No ☐ Yes

7. Wake up during night, can't fall back asleep ☐ No ☐ Yes

8. Sleep walk ☐ No ☐ Yes

Do you have any other symptoms that have not been covered in this questionnaire? _____

MEDICATION AND SUPPLEMENT LOG & FOOD DIARY

Name _____ Date _____

Please list medications first. If medication, please list the dosage.

Name of Medication or Supplement:	Total Number Per Day

Food Diary: Please list everything you ate and drank for the last three days:

Day 1:

Breakfast: _____

Lunch: _____

Supper: _____

Snacks (specify time): _____

Day 2:

Breakfast: _____

Lunch: _____

Supper: _____

Snacks (specify time): _____

Day 3:

Breakfast: _____

Lunch: _____

Supper: _____

Snacks (specify time): _____