

Please list any medications you are currently taking (names & dosages)

Family Medical History

Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- Diabetes ___ Seizures ___ Heart Disease ___ Stroke ___
 High Blood Pressure ___ Allergies ___ Cancer ___ Asthma ___
 Other _____

Please give a general description of your weekly diet (breakfast, lunch, dinner, snacks)

Please list all vitamins and supplements you take regularly

Any diet restrictions? Yes No (if yes, please describe below)

Describe type and weekly use (# per) of

Caffeinated drinks

Alcohol

Recreational drugs

Do you exercise? Yes No

Type of exercise/ frequency

Personal History Please check any conditions or symptoms you have now.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Diverticulitis/IBS |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Raynaud's Disease |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Allergies |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Anemia | <input type="checkbox"/> Thyroid Imbalance | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Chronic Pain Condition | |
| <input type="checkbox"/> Gastritis/Pancreatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility <input type="checkbox"/> Emphysema | |
| <input type="checkbox"/> Elevated Blood Cholesterol | | | |

Please check any sign/symptom that is a current issue or has occurred within the past year.

General

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Sleeping | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fevers |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Sweats Easily | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance | <input type="checkbox"/> Bleed/Bruise easily |
| <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Peculiar tastes/smells | <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Sudden energy drop |
| <input type="checkbox"/> Strong thirst (hot or cold drinks) | | | |

Skin and Hair

- | | | | |
|---|--------------------------------------|--|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne | <input type="checkbox"/> Change in skin/hair texture | |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Warts | <input type="checkbox"/> Fungal Infection | <input type="checkbox"/> Weak or ridged nai |

Head, Eyes, Ears, Nose and Throat

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Migraines | <input type="checkbox"/> Glasses |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental problems | <input type="checkbox"/> Jaw clicks/locks | <input type="checkbox"/> Headaches |

Cardiovascular

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Swelling of hands/feet | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Varicose/spider veins | <input type="checkbox"/> Pressure in chest | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Spontaneous sweating | <input type="checkbox"/> Dizziness | |

Respiratory

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Cough/Wheezing | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest | <input type="checkbox"/> Difficult inhale/exhale |
| <input type="checkbox"/> Difficulty breathing when lying down | | <input type="checkbox"/> Production of phlegm... what color? _____ | |

Gastrointestinal

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools | <input type="checkbox"/> Blood in stool |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Bloating/Edema | <input type="checkbox"/> Abdominal pain/cramps | <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/GERD |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Significant thirst | <input type="checkbox"/> IBS/Crohn's Disease | |

Genito-Urinary

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urgent urination |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Scanty flow | <input type="checkbox"/> Copious flow | <input type="checkbox"/> Urinary tract infection |
| <input type="checkbox"/> Burning urination | <input type="checkbox"/> Dribbling after urination | <input type="checkbox"/> Night Urination | <input type="checkbox"/> Infections |

Musculoskeletal

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sprains/Strains | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Foot/ankle pain |
| <input type="checkbox"/> Hip pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Back pain Low___ Middle___ Upper___ | | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Rotator Cuff |

Neuropsychological

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Vertigo/Dizziness | <input type="checkbox"/> Areas of numbness |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety/Panic attacks | <input type="checkbox"/> Bad temper/irritable | <input type="checkbox"/> Easily susceptible to stress | |
| <input type="checkbox"/> Seasonal Affective Disorder | | | |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Manic Depression | |

For Men only

- | | | | |
|---------------------------------------|--|--|---|
| <input type="checkbox"/> Genital pain | <input type="checkbox"/> Low sexual energy | <input type="checkbox"/> Genital sores | <input type="checkbox"/> Lumps in testicles |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Penis discharge | | |

For Women only

- | | | |
|--|---|--|
| <input type="checkbox"/> Difficult/Painful intercourse | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Age of first menses _____ |
| <input type="checkbox"/> Vaginal dryness | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Date of last menses _____ |
| <input type="checkbox"/> Vaginal sores | <input type="checkbox"/> Uterine Fibroids | <input type="checkbox"/> Date of last PAP/Pelvic _____ |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Fibrocystic breast tissue | <input type="checkbox"/> Number of pregnancies ____ |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Polycystic Ovarian Disease | <input type="checkbox"/> Number of ectopic pregnancies _____ |
| <input type="checkbox"/> Irregular menstruation | <input type="checkbox"/> Painful menstruation | <input type="checkbox"/> Number of live births _____ |
| <input type="checkbox"/> Low sexual energy | | <input type="checkbox"/> Number of miscarriages _____ |

Irregular PAP?

If yes, date(s) and treatment _____

Is your period regular? Yes No How long is your cycle? _____

How many days of flow? _____

Please describe any PMS signs/symptoms _____

Do you practice birth control? Y / N

What type? _____

For how long? _____

Please feel free to list/ describe any other issues you would like to discuss