

REVIEW OF SYMPTOMS: Check the symptoms that apply to you. Note whether the symptom is past, now or both:

<input type="checkbox"/> Past <input type="checkbox"/> Now-Get infections easy	<input type="checkbox"/> Past <input type="checkbox"/> - Now - Chronic pain	<input type="checkbox"/> Past <input type="checkbox"/> Now-Tired without effort
<input type="checkbox"/> Past <input type="checkbox"/> - Now - Fever	<input type="checkbox"/> Past <input type="checkbox"/> -Now Flu like symptoms	<input type="checkbox"/> Past <input type="checkbox"/> Now - Chills
<input type="checkbox"/> Past <input type="checkbox"/> - Now Night Sweat	<input type="checkbox"/> Past <input type="checkbox"/> Now - Cold Intolerance	<input type="checkbox"/> Past <input type="checkbox"/> Now - Heat Intolerance
<input type="checkbox"/> Past <input type="checkbox"/> Now-Weight gain ___lbs	<input type="checkbox"/> Past <input type="checkbox"/> Now-Weight Loss ___lbs	<input type="checkbox"/> Past <input type="checkbox"/> Now – Can't decide easily
<input type="checkbox"/> Past <input type="checkbox"/> Now – Thinking difficulties	<input type="checkbox"/> Past <input type="checkbox"/> Now – Poor Memory (long term)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Poor Memory (short term)
<input type="checkbox"/> Past <input type="checkbox"/> Now - Disorientation	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hyperactivity	<input type="checkbox"/> Past <input type="checkbox"/> Now–Constant Movement
<input type="checkbox"/> Past <input type="checkbox"/> Now–Low Activity (Hypo)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sleep too much	<input type="checkbox"/> Past <input type="checkbox"/> Now–Difficulty falling asleep
<input type="checkbox"/> Past <input type="checkbox"/> Now – Frequent awakening	<input type="checkbox"/> Past <input type="checkbox"/> Now - Nightmares	<input type="checkbox"/> Past <input type="checkbox"/> Now – Restless legs
<input type="checkbox"/> Past <input type="checkbox"/> Now – Shingles	<input type="checkbox"/> Past <input type="checkbox"/> Now – Un-refreshed Sleep	<input type="checkbox"/> Past <input type="checkbox"/> Now - Dizziness
<input type="checkbox"/> Past <input type="checkbox"/> Now – Fainting/Blacking out	<input type="checkbox"/> Past <input type="checkbox"/> Now – Convulsions/Seizure	<input type="checkbox"/> Past <input type="checkbox"/> Now – Speech Problem
<input type="checkbox"/> Past <input type="checkbox"/> Now – Burning sensations	<input type="checkbox"/> Past <input type="checkbox"/> Now – Electrical Zaps	<input type="checkbox"/> Past <input type="checkbox"/> Now – Numbness
<input type="checkbox"/> Past <input type="checkbox"/> Now – Tingling	<input type="checkbox"/> Past <input type="checkbox"/> Now – Headaches	<input type="checkbox"/> Past <input type="checkbox"/> Now – Weakness
<input type="checkbox"/> Past <input type="checkbox"/> Now – Clumsiness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Tremors	<input type="checkbox"/> Past <input type="checkbox"/> Now – Accident Prone
<input type="checkbox"/> Past <input type="checkbox"/> Now–Repeats same action(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Head Banging	<input type="checkbox"/> Past <input type="checkbox"/> Now – Picking
<input type="checkbox"/> Past <input type="checkbox"/> Now – Poor Sense of Smell	<input type="checkbox"/> Past <input type="checkbox"/> Now – Paralysis	<input type="checkbox"/> Past <input type="checkbox"/> Now – Highly Charged Emotional Memories
<input type="checkbox"/> Past <input type="checkbox"/> Now – Anxiety/Nerves on edge	<input type="checkbox"/> Past <input type="checkbox"/> Now – Apprehension	<input type="checkbox"/> Past <input type="checkbox"/> Now – Fearful
<input type="checkbox"/> Past <input type="checkbox"/> Now – Fearful of going out	<input type="checkbox"/> Past <input type="checkbox"/> Now – Other specific fear:	
<input type="checkbox"/> Past <input type="checkbox"/> Now – Panic episodes	<input type="checkbox"/> Past <input type="checkbox"/> Now – Flashback Memories:	
<input type="checkbox"/> Past <input type="checkbox"/> Now–Sad/Depressed Mood	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hopelessness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Unworthy Guilt
<input type="checkbox"/> Past <input type="checkbox"/> Now – Loss of interest in life	<input type="checkbox"/> Past <input type="checkbox"/> Now – Suicidal Thoughts	<input type="checkbox"/> Past <input type="checkbox"/> Now – Suicidal Attempt(s)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Angry Outbursts	<input type="checkbox"/> Past <input type="checkbox"/> Now – Irritable	<input type="checkbox"/> Past <input type="checkbox"/> Now – Mood Swings
<input type="checkbox"/> Past <input type="checkbox"/> Now–Jekyll/Hyde personality	<input type="checkbox"/> Past <input type="checkbox"/> Now – Negative/Hostile	<input type="checkbox"/> Past <input type="checkbox"/> Now – Stress @ Work
<input type="checkbox"/> Past <input type="checkbox"/> Now – Stress @ Home	<input type="checkbox"/> Past <input type="checkbox"/> Now – Stress in a Relationship – Explain:	

What are your other major stressors?

<input type="checkbox"/> Past <input type="checkbox"/> Now – Anorexia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Binge Eating	<input type="checkbox"/> Past <input type="checkbox"/> Now – Impulsive eating
<input type="checkbox"/> Past <input type="checkbox"/> Now – Purging	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sugar Cravings	<input type="checkbox"/> Past <input type="checkbox"/> Now – Anti Social Behaviors
<input type="checkbox"/> Past <input type="checkbox"/> Now–Compulsive behaviors	<input type="checkbox"/> Past <input type="checkbox"/> Now – Obsessive behaviors	<input type="checkbox"/> Past <input type="checkbox"/> Now – Defiant behavior
<input type="checkbox"/> Past <input type="checkbox"/> Now – Worry	<input type="checkbox"/> Past <input type="checkbox"/> Now – Temper Tantrums	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hallucinations
<input type="checkbox"/> Past <input type="checkbox"/> Now – Manic Episodes	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vision Loss	<input type="checkbox"/> Past <input type="checkbox"/> Now-Rapid vision change
<input type="checkbox"/> Past <input type="checkbox"/> Now – Blurry Vision	<input type="checkbox"/> Past <input type="checkbox"/> Now – Spots/floaters/eyes	<input type="checkbox"/> Past <input type="checkbox"/> Now – Wear glasses
<input type="checkbox"/> Past <input type="checkbox"/> Now – Wear Contact Lenses	<input type="checkbox"/> Past <input type="checkbox"/> Now – Pain in eye(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Red eye(s)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Dryness (eyes)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Light Sensitivity	<input type="checkbox"/> Past <input type="checkbox"/> Now – Swelling of eye(s)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Itchy eye(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Watery/Teary	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cataract(s)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Glaucoma	<input type="checkbox"/> Past <input type="checkbox"/> Now – Infection	<input type="checkbox"/> Past <input type="checkbox"/> Now – Head Tenderness
<input type="checkbox"/> Past <input type="checkbox"/> Now – Jaw Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Neck stiffness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Neck Tenderness
<input type="checkbox"/> Past <input type="checkbox"/> Now – Swelling	<input type="checkbox"/> Past <input type="checkbox"/> Now – Swollen Glands	<input type="checkbox"/> Past <input type="checkbox"/> Now – Lump(s)
<input type="checkbox"/> Past <input type="checkbox"/> Now–Breath through mouth	<input type="checkbox"/> Past <input type="checkbox"/> Now – Recurrent Infections	<input type="checkbox"/> Past <input type="checkbox"/> Now–Drainage/Discharge
<input type="checkbox"/> Past <input type="checkbox"/> Now – Earaches	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hearing Loss	<input type="checkbox"/> Past <input type="checkbox"/> Now – Wear Hearing Aid
<input type="checkbox"/> Past <input type="checkbox"/> Now – Itching (ears)	<input type="checkbox"/> Past <input type="checkbox"/> Now–Noise Sensitivity (ears)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Tinnitus
<input type="checkbox"/> Past <input type="checkbox"/> Now – Vertigo	<input type="checkbox"/> Past <input type="checkbox"/> Now – Redness (ears)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Frequent Colds
<input type="checkbox"/> Past <input type="checkbox"/> Now – Congestion	<input type="checkbox"/> Past <input type="checkbox"/> Now – Runny Nose	<input type="checkbox"/> Past <input type="checkbox"/> Now – Post Nasal Drip
<input type="checkbox"/> Past <input type="checkbox"/> Now – Nose Blockage	<input type="checkbox"/> Past <input type="checkbox"/> Now – Itching (nose)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sneezing
<input type="checkbox"/> Past <input type="checkbox"/> Now – Nose Bleeds	<input type="checkbox"/> Past <input type="checkbox"/> Now – Snoring	<input type="checkbox"/> Past <input type="checkbox"/> Now – Facial Pain
<input type="checkbox"/> Past <input type="checkbox"/> Now – Sinus Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cracked Lips	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sore Lips
<input type="checkbox"/> Past <input type="checkbox"/> Now – Dry mouth	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sores in Mouth	<input type="checkbox"/> Past <input type="checkbox"/> Now – Ulcers in Mouth
<input type="checkbox"/> Past <input type="checkbox"/> Now – Bad Breath	<input type="checkbox"/> Past <input type="checkbox"/> Now – Coated Tongue	<input type="checkbox"/> Past <input type="checkbox"/> Now – Abnormal Taste
<input type="checkbox"/> Past <input type="checkbox"/> Now – Metallic Taste	<input type="checkbox"/> Past <input type="checkbox"/> Now – Gum Problems	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bleeding Gums
<input type="checkbox"/> Past <input type="checkbox"/> Now – Toothache	<input type="checkbox"/> Past <input type="checkbox"/> Now – Loose/Missing Teeth	<input type="checkbox"/> Past <input type="checkbox"/> Now – Grinding Teeth

<input type="checkbox"/> Past <input type="checkbox"/> Now – Chewing difficulty	<input type="checkbox"/> Past <input type="checkbox"/> Now – Silver (metal) fillings	<input type="checkbox"/> Past <input type="checkbox"/> Now – Dentures
<input type="checkbox"/> Past <input type="checkbox"/> Now – Sore Throats-frequent	<input type="checkbox"/> Past <input type="checkbox"/> Now – Swollen Tonsils	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hoarseness
<input type="checkbox"/> Past <input type="checkbox"/> Now – Short of Breath @ rest	<input type="checkbox"/> Past <input type="checkbox"/> Now – Short of Breath-exertion	<input type="checkbox"/> Past <input type="checkbox"/> Now – Short of Breath -lying
<input type="checkbox"/> Past <input type="checkbox"/> Now – Rattling Mucous	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sensitive to smog	<input type="checkbox"/> Past <input type="checkbox"/> Now – Pneumonia
<input type="checkbox"/> Past <input type="checkbox"/> Now – Wheezing	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cough-occasional	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cough all the time
<input type="checkbox"/> Past <input type="checkbox"/> Now – Cough – dry	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cough–Phlegm/blood	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cough with Blood
<input type="checkbox"/> Past <input type="checkbox"/> Now – Exposed to chemicals Radiation/asbestos	<input type="checkbox"/> Past <input type="checkbox"/> Now – Pain in Ribs/Infections settle in lung	<input type="checkbox"/> Past <input type="checkbox"/> Now – Chest pain @ rest
<input type="checkbox"/> Past <input type="checkbox"/> Now – Chest Pain-Exertion	<input type="checkbox"/> Past <input type="checkbox"/> Now – Exhaust Minor Exertion	<input type="checkbox"/> Past <input type="checkbox"/> Now – Chest Pressure
<input type="checkbox"/> Past <input type="checkbox"/> Now – Fast Heart Rate	<input type="checkbox"/> Past <input type="checkbox"/> Now – Slow Heart Rate	<input type="checkbox"/> Past <input type="checkbox"/> Now – Heart Skips a Beat
<input type="checkbox"/> Past <input type="checkbox"/> Now – Palpitations	<input type="checkbox"/> Past <input type="checkbox"/> Now – Heart Pounds Easily	<input type="checkbox"/> Past <input type="checkbox"/> Now – Coldness of hands/feet
<input type="checkbox"/> Past <input type="checkbox"/> Now – Blue Hands/feet/cold	<input type="checkbox"/> Past <input type="checkbox"/> Now – Do you Exercise?	<input type="checkbox"/> Past <input type="checkbox"/> Now – Headaches
<input type="checkbox"/> Past <input type="checkbox"/> Now – Heartburn	<input type="checkbox"/> Past <input type="checkbox"/> Now – Fingertips Discolored	<input type="checkbox"/> Past <input type="checkbox"/> Now – Fingertips White
<input type="checkbox"/> Past <input type="checkbox"/> Now – Leg pain when walking	<input type="checkbox"/> Past <input type="checkbox"/> Now – Ear Canal Hair	<input type="checkbox"/> Past <input type="checkbox"/> Now – 5 or more cups of coffee a day
<input type="checkbox"/> Past <input type="checkbox"/> Now – Swelling feet/legs	<input type="checkbox"/> Past <input type="checkbox"/> Now – Ulcers of feet/legs	<input type="checkbox"/> Past <input type="checkbox"/> Now – Varicose Veins
<input type="checkbox"/> Past <input type="checkbox"/> Now – Difficulty breathing at night		
<input type="checkbox"/> Past <input type="checkbox"/> Now – Spider Veins nose/face	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blood Pressure Low	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blood Pressure High
<input type="checkbox"/> Past <input type="checkbox"/> Now – Change of Appetite	<input type="checkbox"/> Past <input type="checkbox"/> Now – Ravenous Appetite	<input type="checkbox"/> Past <input type="checkbox"/> Now – Poor/Loss of Appetite
<input type="checkbox"/> Past <input type="checkbox"/> Now – Abdominal Cramps/Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – On a Weight Loss Diet	<input type="checkbox"/> Past <input type="checkbox"/> Now – Mucous in Stools
<input type="checkbox"/> Past <input type="checkbox"/> Now – Difficulty Chewing	<input type="checkbox"/> Past <input type="checkbox"/> Now – Difficulty/Pain Swallowing	<input type="checkbox"/> Past <input type="checkbox"/> Now – Stomach fills up quickly
<input type="checkbox"/> Past <input type="checkbox"/> Now – Indigestion	<input type="checkbox"/> Past <input type="checkbox"/> Now – Use Antacids	<input type="checkbox"/> Past <input type="checkbox"/> Now – Belching
<input type="checkbox"/> Past <input type="checkbox"/> Now – Reflux	<input type="checkbox"/> Past <input type="checkbox"/> Now – Nausea	<input type="checkbox"/> Past <input type="checkbox"/> Now – Alternate Diarrhea/Constipation
<input type="checkbox"/> Past <input type="checkbox"/> Now – Vomiting	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vomiting Blood	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vomiting Projectile
<input type="checkbox"/> Past <input type="checkbox"/> Now – Excessive Burping	<input type="checkbox"/> Past <input type="checkbox"/> Now – Abdominal Lump/Mass	<input type="checkbox"/> Past <input type="checkbox"/> Now – Abdominal Bloating
<input type="checkbox"/> Past <input type="checkbox"/> Now – Abdominal Distension	<input type="checkbox"/> Past <input type="checkbox"/> Now – Abdominal Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Distress from eating
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hernia	<input type="checkbox"/> Past <input type="checkbox"/> Now – History Ulcer or Gastritis	

Food Intolerances: Please list past and/or present food triggered symptoms (any symptoms).

<u>Food</u>	<u>Symptom(s)</u>	<u>Food</u>	<u>Symptom(s)</u>
<input type="checkbox"/> Past <input type="checkbox"/> Now _____	_____	<input type="checkbox"/> Past <input type="checkbox"/> Now _____	_____
<input type="checkbox"/> Past <input type="checkbox"/> Now _____	_____	<input type="checkbox"/> Past <input type="checkbox"/> Now _____	_____
<input type="checkbox"/> Past <input type="checkbox"/> Now _____	_____	<input type="checkbox"/> Past <input type="checkbox"/> Now _____	_____

<input type="checkbox"/> Past <input type="checkbox"/> Now – Colitis	<input type="checkbox"/> Past <input type="checkbox"/> Now – Gas/Flatus-excessive	<input type="checkbox"/> Past <input type="checkbox"/> Now – Constipation
<input type="checkbox"/> Past <input type="checkbox"/> Now – Uses Laxatives	<input type="checkbox"/> Past <input type="checkbox"/> Now – Diarrhea	<input type="checkbox"/> Past <input type="checkbox"/> Now – Can't Control bowels
<input type="checkbox"/> Past <input type="checkbox"/> Now – Change in bowel habits	<input type="checkbox"/> Past <input type="checkbox"/> Now – Abnormal Stools/Poorly Formed	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blood in Stools
<input type="checkbox"/> Past <input type="checkbox"/> Now – Black/Tar-like stools	<input type="checkbox"/> Past <input type="checkbox"/> Now – Undigested food in stool	<input type="checkbox"/> Past <input type="checkbox"/> Now – Rectal Fistula
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hemorrhoids	<input type="checkbox"/> Past <input type="checkbox"/> Now – Rectal Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Rectal Itching
<input type="checkbox"/> Past <input type="checkbox"/> Now – Bed Wetting	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bladder Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Recurrent Ur Infections
<input type="checkbox"/> Past <input type="checkbox"/> Now – Urine Dribbling	<input type="checkbox"/> Past <input type="checkbox"/> Now – Painful Urination	<input type="checkbox"/> Past <input type="checkbox"/> Now – Urine Urgency
<input type="checkbox"/> Past <input type="checkbox"/> Now – Urine Frequency	<input type="checkbox"/> Past <input type="checkbox"/> Now – Wake Up to Urinate	<input type="checkbox"/> Past <input type="checkbox"/> Now – Slow Stream
<input type="checkbox"/> Past <input type="checkbox"/> Now – Incontinence	<input type="checkbox"/> Past <input type="checkbox"/> Now – Loss of Urine	<input type="checkbox"/> Past <input type="checkbox"/> Now – Back Pain in Kidney area
<input type="checkbox"/> Past <input type="checkbox"/> Now – Urinate Very Little	<input type="checkbox"/> Past <input type="checkbox"/> Now – Urinate a lot	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blood in Urine
<input type="checkbox"/> Past <input type="checkbox"/> Now – Cloudy Urine	<input type="checkbox"/> Past <input type="checkbox"/> Now – Dark Urine	<input type="checkbox"/> Past <input type="checkbox"/> Now – Strong Smelling Urine
<input type="checkbox"/> Past <input type="checkbox"/> Now – Red Urine	<input type="checkbox"/> Past <input type="checkbox"/> Now – Water Retention	<input type="checkbox"/> Past <input type="checkbox"/> Now – Tea Colored Urine

FEMALE (ONLY)

<input type="checkbox"/> Past <input type="checkbox"/> Now – Breast Feeding	<input type="checkbox"/> Past <input type="checkbox"/> Now – Breast Lump	<input type="checkbox"/> Past <input type="checkbox"/> Now – Nipple Discharge
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<input type="checkbox"/> Past <input type="checkbox"/> Now – Breast Pain/Tenderness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hot Flashes/Night Sweats	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sexually Active
<input type="checkbox"/> Past <input type="checkbox"/> Now – Abstinent	<input type="checkbox"/> Past <input type="checkbox"/> Now – Decreased Sex Drive	<input type="checkbox"/> Past <input type="checkbox"/> Now – Infertility
<input type="checkbox"/> Past <input type="checkbox"/> Now – Pelvic Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Pain w/ intercourse/dryness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Uterine Cysts
<input type="checkbox"/> Past <input type="checkbox"/> Now – Genital Rash	<input type="checkbox"/> Past <input type="checkbox"/> Now – Genital Lesions	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vaginal Discharge
<input type="checkbox"/> Past <input type="checkbox"/> Now – Vaginal Itch	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vaginal Odor/Discharge	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vaginal Pain
<input type="checkbox"/> Past <input type="checkbox"/> Now – Ovarian Cysts	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bleeding between Cycles	<input type="checkbox"/> Past <input type="checkbox"/> Now – Irregular Bleeding
<input type="checkbox"/> Past <input type="checkbox"/> Now – Monthly Weight Gain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Mid Cycle Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Low Back Pain during Menses
<input type="checkbox"/> Past <input type="checkbox"/> Now – Premenstrual Symptoms (PMS):		
<input type="checkbox"/> Past <input type="checkbox"/> Now – Heavy Menses	<input type="checkbox"/> Past <input type="checkbox"/> Now – Menstrual Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Menstrual Headache
<input type="checkbox"/> Past <input type="checkbox"/> Now – Too Frequent Menses	<input type="checkbox"/> Past <input type="checkbox"/> Now – Infrequent Menses	<input type="checkbox"/> Past <input type="checkbox"/> Now – No Menses
Menses onset @ age _____	Cycle every _____ days; lasting _____ days	Menopause @ age: _____
<input type="checkbox"/> Past <input type="checkbox"/> Now – Menopause Symptoms (do you feel less feminine than desired):		
<input type="checkbox"/> Past <input type="checkbox"/> Now – Post Menopause bleeding		

MALE (ONLY)

<input type="checkbox"/> Past <input type="checkbox"/> Now – Slow in Maturing	<input type="checkbox"/> Past <input type="checkbox"/> Now – Genital Lesions	<input type="checkbox"/> Past <input type="checkbox"/> Now – Scrotal Rash/Lesions
<input type="checkbox"/> Past <input type="checkbox"/> Now – Penile Rash/Lesions	<input type="checkbox"/> Past <input type="checkbox"/> Now – Penile Discharge	<input type="checkbox"/> Past <input type="checkbox"/> Now – Testicle Pain
<input type="checkbox"/> Past <input type="checkbox"/> Now – Infertility	<input type="checkbox"/> Past <input type="checkbox"/> Now – Prostate Problem	<input type="checkbox"/> Past <input type="checkbox"/> Now – Varicose Veins on Scrotum
<input type="checkbox"/> Past <input type="checkbox"/> Now – Sexually Active	<input type="checkbox"/> Past <input type="checkbox"/> Now – Abstinent	<input type="checkbox"/> Past <input type="checkbox"/> Now – Decreased Sex Desire
<input type="checkbox"/> Past <input type="checkbox"/> Now – Poor Erection	<input type="checkbox"/> Past <input type="checkbox"/> Now – Impotent / no erection	<input type="checkbox"/> Past <input type="checkbox"/> Now – Pain with Ejaculation
<input type="checkbox"/> Past <input type="checkbox"/> Now – Premature Ejaculation	<input type="checkbox"/> Past <input type="checkbox"/> Now – No Ejaculation	<input type="checkbox"/> Past <input type="checkbox"/> Now – Ejaculation while asleep
<input type="checkbox"/> Past <input type="checkbox"/> Now – pain with Intercourse		

BOTH MALE AND FEMALE TO ANSWER THE FOLLOWING QUESTIONS:

<input type="checkbox"/> Past <input type="checkbox"/> Now – General Aches	<input type="checkbox"/> Past <input type="checkbox"/> Now – Artificial Joint(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Muscle loss (atrophy)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Bone Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Limited Motion	<input type="checkbox"/> Past <input type="checkbox"/> Now – Morning Stiffness
<input type="checkbox"/> Past <input type="checkbox"/> Now – Rheumatoid Arthritis	<input type="checkbox"/> Past <input type="checkbox"/> Now – Muscle Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Muscle Spasms
<input type="checkbox"/> Past <input type="checkbox"/> Now – Muscle Weakness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Muscle Twitches	<input type="checkbox"/> Past <input type="checkbox"/> Now – Osteo Arthritis
<input type="checkbox"/> Past <input type="checkbox"/> Now – Joints Hurt/Painful	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bursitis	<input type="checkbox"/> Past <input type="checkbox"/> Now – Osteoporosis
<input type="checkbox"/> Past <input type="checkbox"/> Now – Joints Stiff	<input type="checkbox"/> Past <input type="checkbox"/> Now – Joints Red	<input type="checkbox"/> Past <input type="checkbox"/> Now – Joint Swelling
<input type="checkbox"/> Past <input type="checkbox"/> Now – Tendonitis	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bone Fractures	<input type="checkbox"/> Past <input type="checkbox"/> Now – Neck Pain/Shoulder
<input type="checkbox"/> Past <input type="checkbox"/> Now – Mid-Back Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Low Back Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Slipped Disc
<input type="checkbox"/> Past <input type="checkbox"/> Now – Herniated Disc	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sciatica	<input type="checkbox"/> Past <input type="checkbox"/> Now – Arm Pain
<input type="checkbox"/> Past <input type="checkbox"/> Now – Arm Swelling	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hand Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hand Swelling
<input type="checkbox"/> Past <input type="checkbox"/> Now – Leg Pain	<input type="checkbox"/> Past <input type="checkbox"/> Now – Leg Cramps	<input type="checkbox"/> Past <input type="checkbox"/> Now – Feet Pain
<input type="checkbox"/> Past <input type="checkbox"/> Now – Feet Burning	<input type="checkbox"/> Past <input type="checkbox"/> Now – Loss in Height	<input type="checkbox"/> Past <input type="checkbox"/> Now – Swollen Knees/Elbows
<input type="checkbox"/> Past <input type="checkbox"/> Now – Double Joints	<input type="checkbox"/> Past <input type="checkbox"/> Now – Feet Cramps	<input type="checkbox"/> Past <input type="checkbox"/> Now – Feet Swelling
<input type="checkbox"/> Past <input type="checkbox"/> Now – Flat Feet	<input type="checkbox"/> Past <input type="checkbox"/> Now – Difficulty w/ Walking	<input type="checkbox"/> Past <input type="checkbox"/> Now – Rashes
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hair grows slowly	<input type="checkbox"/> Past <input type="checkbox"/> Now – Eczema	<input type="checkbox"/> Past <input type="checkbox"/> Now – Excessive Dry Skin
<input type="checkbox"/> Past <input type="checkbox"/> Now – Itchy Skin	<input type="checkbox"/> Past <input type="checkbox"/> Now – Excessive Sweating	<input type="checkbox"/> Past <input type="checkbox"/> Now – Redness (skin)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Scar(s)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Unusual Texture (skin)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cracking (skin)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Scaling (skin)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Moles	<input type="checkbox"/> Past <input type="checkbox"/> Now – Moles Changing
<input type="checkbox"/> Past <input type="checkbox"/> Now – Boils/Styes	<input type="checkbox"/> Past <input type="checkbox"/> Now – Increase Skin Pigment	<input type="checkbox"/> Past <input type="checkbox"/> Now – Loss Skin Pigment
<input type="checkbox"/> Past <input type="checkbox"/> Now – Acne	<input type="checkbox"/> Past <input type="checkbox"/> Now – Skin Cancer	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hives
<input type="checkbox"/> Past <input type="checkbox"/> Now – Warts	<input type="checkbox"/> Past <input type="checkbox"/> Now – Skin Ulcers	<input type="checkbox"/> Past <input type="checkbox"/> Now – Cold Sore/Fever Blisters
<input type="checkbox"/> Past <input type="checkbox"/> Now – Body Odor	<input type="checkbox"/> Past <input type="checkbox"/> Now – Brittle Nails	<input type="checkbox"/> Past <input type="checkbox"/> Now – Thickened Nails

<input type="checkbox"/> Past <input type="checkbox"/> Now – Discolored Nails	<input type="checkbox"/> Past <input type="checkbox"/> Now – Pitted Nails	<input type="checkbox"/> Past <input type="checkbox"/> Now – Inflamed Cuticles
<input type="checkbox"/> Past <input type="checkbox"/> Now – Ingrown Nail	<input type="checkbox"/> Past <input type="checkbox"/> Now – Fungal Infection Nails	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blue Nails
<input type="checkbox"/> Past <input type="checkbox"/> Now – “Spoon” Shaped Nails	<input type="checkbox"/> Past <input type="checkbox"/> Now – Dry Hair	<input type="checkbox"/> Past <input type="checkbox"/> Now – Oily Hair
<input type="checkbox"/> Past <input type="checkbox"/> Now – Dandruff	<input type="checkbox"/> Past <input type="checkbox"/> Now – Scalp Itch	<input type="checkbox"/> Past <input type="checkbox"/> Now – Oily Skin
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hair Loss	<input type="checkbox"/> Past <input type="checkbox"/> Now – Increased Hair Growth	<input type="checkbox"/> Past <input type="checkbox"/> Now – Processes/Dye Hair
<input type="checkbox"/> Past <input type="checkbox"/> Now – Premature aging/Wrinkly Skin	<input type="checkbox"/> Past <input type="checkbox"/> Now – Face/Eyelids Puffy	<input type="checkbox"/> Past <input type="checkbox"/> Now – Rapid Growth
<input type="checkbox"/> Past <input type="checkbox"/> Now – Slow Growth	<input type="checkbox"/> Past <input type="checkbox"/> Now – Overweight	<input type="checkbox"/> Past <input type="checkbox"/> Now – Underweight
<input type="checkbox"/> Past <input type="checkbox"/> Now – Can’t Gain Weight	<input type="checkbox"/> Past <input type="checkbox"/> Now – Can’t Lose Weight	<input type="checkbox"/> Past <input type="checkbox"/> Now – Thyroid Goiter
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hot Flashes	<input type="checkbox"/> Past <input type="checkbox"/> Now – Too Thirsty	<input type="checkbox"/> Past <input type="checkbox"/> Now – No Thirst
<input type="checkbox"/> Past <input type="checkbox"/> Now – No Thirst	<input type="checkbox"/> Past <input type="checkbox"/> Now – Drink A lot	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sub-normal Temp
<input type="checkbox"/> Past <input type="checkbox"/> Now – Known Hormonal Imbalance	<input type="checkbox"/> Past <input type="checkbox"/> Now – Easy Bleeding	<input type="checkbox"/> Past <input type="checkbox"/> Now – Prolonged Bleeding
<input type="checkbox"/> Past <input type="checkbox"/> Now – Poor Wound Healing	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blood Clot	<input type="checkbox"/> Past <input type="checkbox"/> Now – Easy Bruising
<input type="checkbox"/> Past <input type="checkbox"/> Now – Frequent Bruising	<input type="checkbox"/> Past <input type="checkbox"/> Now – Lymph Node Swelling	<input type="checkbox"/> Past <input type="checkbox"/> Now – Dark Circles Under the eyes
<input type="checkbox"/> Past <input type="checkbox"/> Now – Swollen Lymph Glands		

Allergy and Environmental: Check those symptoms affected by the following environmental patterns:

Pattern	Nose	Eye	Lung	Skin	Other Body Symptom
Worse Indoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Improved Indoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Increased symptoms within 30 min. of going to bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Symptoms recur/increase w/ cold weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse in Air Conditioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse/Dusting/sweeping (dust exposure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse outdoors from 4:40 – 8:30 p.m.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse in cool evening air	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse damp places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse Basements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse w/ mold/mildew exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse raking or exposure to leaves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse Sept to heavy/killing frost	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse outdoors 7 – 11:00 a.m.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Improved indoors, especially w/ air conditioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse exposure to feed mills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse in barns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse after exposure to cats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse after exposure to dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse exposure to other Animal: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insect Reaction, (name insect(s)): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse with/after exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse when hot or overheated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse with cold exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Present or worse winter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Present or worse spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Present or worse fall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Present all year (all the time)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse with storm fronts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse with wind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse on dry day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Worse with high humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Worse from the following Chemical Exposure:

Pattern	Nose	Eye	Lung	Skin	Other Body Symptom
Gasoline Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Exhaust Fumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Asphalt, Tar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Polishes, floor Waxes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Moth Balls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Varnish, Paint, Shellac	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
New Cars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Latex Gloves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Soaps/Detergents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Chlorinated Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ammonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bleach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Household Cleaners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Disinfectants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cosmetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hair Spray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Air Fresheners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Newsprint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco Smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Metals/Jewelry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insect Sprays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rubber Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other Chemical(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Home/School Environment: Complete the following to the best of your knowledge. Skip if unknown.

Home Environment:

Pets: Dog(s) Cat(s) Other: _____

Do you live in a: Single House Apartment Mobile Home Other: _____

Age of the house/place you lived: _____ How long have you lived there? _____

Live on a farm In a wooded area Near a swamp Near stream City Suburbs

Near chemical factory/smoke stack Heavy traffic Near power lines/transformers

Did your medical symptoms or problems begin after moving into your current residence?

Yes No Don't know

Are your symptoms better when you are away from your current residence?

Yes No Don't know

What part of your residence do you feel best? _____ Feel the worst? _____

In which part of your residence do you spend the most time? _____

Is the **Garage:** Attached Detached Breezeway Underneath

Is the **Basement:** Dry Damp Musty Flooded in past Can see mold

Is the **Insulation:** Fiberglass Cellulose Sawdust Styrofoam Urea Foam

Are the **Carpets:** Wall to Wall Area rugs Cotton Wool Synthetic

Is the **Heat:** Electric Gas Oil Solar Forced Hot Air Coal Space Heater Wood Burning Stove

Hot Water Heater: Electric Gas Oil Solar

Air Conditioner: Central Air Room Units

Humidifier: On furnace Room Unit Dehumidifier

Is the **Stove:** Gas Electric Is the **Dryer:** Gas Electric

Air Purifier: Central Unit Room Units

Are the **filters:** HEPA Charcoal UV lights Fiberglass Electrostatic Ozone Generator Ionizer
 Other: _____

Other: Use Air Fresheners Use Mothballs Use fluoridated toothpaste

Termite Treatment: No Yes Chemical Name: _____

Pesticide Use: No Yes Chemical Name: _____

Lawn Sprays: No Yes Chemical Name: _____

Work Environment:

At **work** my symptoms are: Worse Better Same/No Change

Is there any particular **place or room** at work which bothers you or aggravates your symptoms?

Has the air quality in your work been a concern to your or others? Explain: _____

PAST MEDICAL HISTORY: Answer to the best of your ability, any question you don't know, just leave it blank.

Past Illnesses: Check the disease or conditions that apply to you. Please note whether the problem is now, past or both:

<input type="checkbox"/> Past <input type="checkbox"/> Now – Birth Defects	<input type="checkbox"/> Past <input type="checkbox"/> Now – Genetic Illness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bacterial Infections
Other Virus: _____	<input type="checkbox"/> Past <input type="checkbox"/> Now – Chicken Pox	<input type="checkbox"/> Past <input type="checkbox"/> Now – Croup
<input type="checkbox"/> Past <input type="checkbox"/> Now – Measles	<input type="checkbox"/> Past <input type="checkbox"/> Now – German Measles	<input type="checkbox"/> Past <input type="checkbox"/> Now – Polio
<input type="checkbox"/> Past <input type="checkbox"/> Now – Rheumatic Fever	<input type="checkbox"/> Past <input type="checkbox"/> Now – Scarlet Fever	<input type="checkbox"/> Past <input type="checkbox"/> Now – Whooping Cough
<input type="checkbox"/> Past <input type="checkbox"/> Now – Mono (EBV)	<input type="checkbox"/> Past <input type="checkbox"/> Now – CMV Virus	<input type="checkbox"/> Past <input type="checkbox"/> Now – Coxsackie Virus
<input type="checkbox"/> Past <input type="checkbox"/> Now – HIV Virus (AIDS)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Lyme Disease	<input type="checkbox"/> Past <input type="checkbox"/> Now – Meningitis
<input type="checkbox"/> Past <input type="checkbox"/> Now – Attention Deficit	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hyperactivity	<input type="checkbox"/> Past <input type="checkbox"/> Now – Learning Problems
<input type="checkbox"/> Past <input type="checkbox"/> Now – Dyslexia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Developmental Delay	<input type="checkbox"/> Past <input type="checkbox"/> Now – Depression
<input type="checkbox"/> Past <input type="checkbox"/> Now – Tension/Anxiety Problem	<input type="checkbox"/> Past <input type="checkbox"/> Now – Post Traumatic Stress	<input type="checkbox"/> Past <input type="checkbox"/> Now – Physical Abuse
<input type="checkbox"/> Past <input type="checkbox"/> Now – Sexual Abuse	<input type="checkbox"/> Past <input type="checkbox"/> Now – Anorexia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bulimia
<input type="checkbox"/> Past <input type="checkbox"/> Now – Migraine Headache	<input type="checkbox"/> Past <input type="checkbox"/> Now – Epilepsy (Seizures)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Heavy Metal Poisoning
<input type="checkbox"/> Past <input type="checkbox"/> Now – Nearsighted	<input type="checkbox"/> Past <input type="checkbox"/> Now – Farsighted	<input type="checkbox"/> Past <input type="checkbox"/> Now – Wears Glasses
<input type="checkbox"/> Past <input type="checkbox"/> Now – Lazy Eye	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blindness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Little Direct Sunlight
<input type="checkbox"/> Past <input type="checkbox"/> Now – Deafness	<input type="checkbox"/> Past <input type="checkbox"/> Now – Wears Hearing Aid	<input type="checkbox"/> Past <input type="checkbox"/> Now – Recurrent Ear Infections
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hay fever/Allergy	<input type="checkbox"/> Past <input type="checkbox"/> Now – Recurrent Sinus Infection	<input type="checkbox"/> Past <input type="checkbox"/> Now – Nose Polyps
<input type="checkbox"/> Past <input type="checkbox"/> Now – Dental Problems	<input type="checkbox"/> Past <input type="checkbox"/> Now – Mouth Ulcers/Sores	<input type="checkbox"/> Past <input type="checkbox"/> Now – Recurrent Tonsillitis
<input type="checkbox"/> Past <input type="checkbox"/> Now – Congenital Heart Disease	<input type="checkbox"/> Past <input type="checkbox"/> Now – Heart Rhythm Problems	<input type="checkbox"/> Past <input type="checkbox"/> Now – Heart Murmur
<input type="checkbox"/> Past <input type="checkbox"/> Now – Mitral Valve Prolapse	<input type="checkbox"/> Past <input type="checkbox"/> Now – Other Heart Valve Problem	<input type="checkbox"/> Past <input type="checkbox"/> Now – Asthma
<input type="checkbox"/> Past <input type="checkbox"/> Now – Recurrent Bronchitis	<input type="checkbox"/> Past <input type="checkbox"/> Now – Pneumonia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Low HDL Cholesterol
<input type="checkbox"/> Past <input type="checkbox"/> Now – Tuberculosis	<input type="checkbox"/> Past <input type="checkbox"/> Now – High Cholesterol	<input type="checkbox"/> Past <input type="checkbox"/> Now – High Tryglycerides
<input type="checkbox"/> Past <input type="checkbox"/> Now – Acid Reflux Stomach	<input type="checkbox"/> Past <input type="checkbox"/> Now – Stomach Ulcer	<input type="checkbox"/> Past <input type="checkbox"/> Now – Lactose Intolerant
<input type="checkbox"/> Past <input type="checkbox"/> Now – Colitis	<input type="checkbox"/> Past <input type="checkbox"/> Now – Crohn's Disease	<input type="checkbox"/> Past <input type="checkbox"/> Now – Celiac Disease
<input type="checkbox"/> Past <input type="checkbox"/> Now – Irritable (spastic) Bowel	<input type="checkbox"/> Past <input type="checkbox"/> Now – Jaundice	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hernia
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hepatitis A	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hepatitis B	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hepatitis C
<input type="checkbox"/> Past <input type="checkbox"/> Now – Dysentery	<input type="checkbox"/> Past <input type="checkbox"/> Now – Parasites	<input type="checkbox"/> Past <input type="checkbox"/> Now – Giardia
<input type="checkbox"/> Past <input type="checkbox"/> Now – Candida	<input type="checkbox"/> Past <input type="checkbox"/> Now – Worms	<input type="checkbox"/> Past <input type="checkbox"/> Now – Gallstones
<input type="checkbox"/> Past <input type="checkbox"/> Now – Bladder Infection	<input type="checkbox"/> Past <input type="checkbox"/> Now – Kidney Infection	<input type="checkbox"/> Past <input type="checkbox"/> Now – Kidney Stones
<input type="checkbox"/> Past <input type="checkbox"/> Now – Vaginitis (yeast)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Vaginitis (other)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Urethral Structure

<input type="checkbox"/> Past <input type="checkbox"/> Now – Venereal Disease	<input type="checkbox"/> Past <input type="checkbox"/> Now – Muscular Distrophy	<input type="checkbox"/> Past <input type="checkbox"/> Now-Rheumatoid Arthritis
<input type="checkbox"/> Past <input type="checkbox"/> Now – Lupus (SLE)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Bone Disease	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sciatica
<input type="checkbox"/> Past <input type="checkbox"/> Now – Whiplash	<input type="checkbox"/> Past <input type="checkbox"/> Now – Eczema	<input type="checkbox"/> Past <input type="checkbox"/> Now – Atopic Dermatitis
<input type="checkbox"/> Past <input type="checkbox"/> Now – Acne	<input type="checkbox"/> Past <input type="checkbox"/> Now – Psoriasis	<input type="checkbox"/> Past <input type="checkbox"/> Now – Seborrhea
<input type="checkbox"/> Past <input type="checkbox"/> Now – Athlete’s Foot	<input type="checkbox"/> Past <input type="checkbox"/> Now – Ringworm	<input type="checkbox"/> Past <input type="checkbox"/> Now – Diabetes
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hypoglycemia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Weight Problem	<input type="checkbox"/> Past <input type="checkbox"/> Now – Hyperthyroidism (high)
<input type="checkbox"/> Past <input type="checkbox"/> Now – Hypothyroidism (low)	<input type="checkbox"/> Past <input type="checkbox"/> Now – Adrenal Problem	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blood Disease
<input type="checkbox"/> Past <input type="checkbox"/> Now – Anemia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Sickle Cell Disease	<input type="checkbox"/> Past <input type="checkbox"/> Now – Blood Transfusion
<input type="checkbox"/> Past <input type="checkbox"/> Now - Thalassemia	<input type="checkbox"/> Past <input type="checkbox"/> Now - Hemophelia	<input type="checkbox"/> Past <input type="checkbox"/> Now-Immune Deficiency
<input type="checkbox"/> Past <input type="checkbox"/> Now – Leukemia	<input type="checkbox"/> Past <input type="checkbox"/> Now – Lymphoma	<input type="checkbox"/> Past <input type="checkbox"/> Now – Heart Attack
<input type="checkbox"/> Past <input type="checkbox"/> Now – Cancer or Tumor	<input type="checkbox"/> Past <input type="checkbox"/> Now – Stroke	

List any other past or present illnesses:

If you were ever **hospitalized** for at least one overnight stay (but did NOT involve surgery or child birth), please describe:

OPERATIONS/SURGERIES: Please list your major operations, including same day surgery. List the name of operation, date it occurred, your age, the reason for the operation, name of the hospital, complications (include any anesthesia reactions). Start with early childhood and list in order to the most recent:

Operation <i>Example: Tonsillectomy</i>	Date <i>02/20/1962</i>	Age <i>5</i>	Reason/Complication <i>Recurrent Sore Thraots</i>	Hospital <i>Shriners Hospital</i>

INJURIES: List any past injuries you have had (not including those stated in the current problem section). Include the type of injury (car accident, fall, broken bones, machinery/occupation accident, etc.), the date it occurred, your age, and any treatment given. Please list from ldest injury to most recent:

Injury <i>Example: Neck Sprain</i>	Date <i>02/20/1985</i>	Age <i>20</i>	How Injury Occurred <i>Car Accident</i>	Treatment Given <i>Chiropractic</i>

HEALTH CARE MAINTENANCE: Please list when you last had the following tests, date, age, location, and the result if known:

Test	Date	Age	Result
Physical Exam			
Rectal Exam			
Stool for Blood			
Colonoscopy			
Sigmoidoscopy			
Cholesterol			
Eye Exam/Vision Test			
Hearing Test			
Dental Exam			

For Women: Do you perform regular (Monthly) self-breast exams? Yes No

Test	Date	Age	Result
Breast Exam by Doctor			
Mammogram			
PAP Smear/Pelvic Exam			

For Men: Do you perform regular (Monthly) self-testicle exams? Yes No

Test	Date	Age	Result
Prostate/Testicle Exam			
PSA Blood Test			

IMMUNIZATIONS: Please list the date and age of any immunization or vaccine you have received and any reaction you may have had (you may bring list on separate sheet from another's physician's office if available)

Immunization	Date	Reaction	Immunization	Date	Reaction
DTaP #1			MMR #1		
DTaP #2			MMR #2		
DTaP #3			PCV (Pneumococcal) #1		
DTaP #4			PCV (Pneumococcal) #2		
DTaP #5			PCV (Pneumococcal) #3		
Tetanus Booster (DT)			PCV (Pneumococcal) #4		
Hib (H.flu) #1			Chickenpox #1		
Hib (H.flu) #2			Chickenpox #2		
Hib (H.flu) #3			Meningococcal		
Hib (H.flu) #4			Last Flu Shot		
Hepatitis B #1			Last Tetanus Shot		
Hepatitis B #2			Last Pneumonia Shot		
Hepatitis B #3			Tuberculosis (TB) Test		
Polio #1			Other:		
Polio #2			Other:		
Polio #3			Other:		
Polio #4			Other:		

OBSTETRICAL/BIRTHING HISTORY: For women, starting with your first pregnancy, please list the date of the birth, how many weeks pregnant you were (ex. Full term, 3 weeks early/late), any complications while you were pregnant, the type of delivery (normal vaginal birth, c-section, forceps, vacuum), sex of the baby, weight of the baby, complications of the delivery, (ex. Needed pitocin, epidural, bleeding problems, shoulder got stuck, baby was

in distress), name of the hospital (list home if home birth). For miscarriages/abortions, list the year and how many weeks pregnant you were and any complications:

Date	Weeks Pregnant	Pregnancy Complications	Type	Sex	Weight	Complications of Delivery	Location

Family History: Please indicate the current status of your immediate family members:

	Alive	Deceased	Age (now or at death)	Comments/Cause of Death
Mother				
Father				
Sister(s)	# _____			
Brother(s)	# _____			
Daughter(s)	# _____			
Son(s)	# _____			

Please indicate with an (x) family members who have had any of the following conditions:

Medical Condition	Mom	Dad	Sister	Bro.	Daug.	Son	Moms Mom	Moms Dad	Dad's Dad	Dad's Mom	Mom's Sister	Mom's Bro.	Dad's Sister	Dad's Bro.
Alcoholism														
Anemia														
Anesthesia problem														
Arthritis														
Asthma														
Autoimmune Disorder														
Birth Defects														
Bleeding Problem														
Cancer, breast														
Cancer, colon														
Cancer, Melanoma														
Cancer, Ovary														
Cancer, Prostate														
Depression														
High Cholesterol														
Diabetes, Type 1 (Childhood onset)														

Medical Condition	Mom	Dad	Sister	Bro.	Daug.	Son	Moms Mom	Moms Dad	Dad's Dad	Dad's Mom	Mom's Sister	Mom's Bro.	Dad's Sister	Dad's Bro.
Diabetes, Type 2 (adult onset)														
Eczema														
Epilepsy (seizure disorder)														
Food Allergies														
Hay Fever														
Hearing Problems														
Heart Attack (coronary artery disease)														
High Cholesterol (Hyperlipidemia)														
High Blood Pressure														
Immuno – Suppressive Disorders														
Kidney Diseases														
Mental Retardation														
Osteoporosis														
Other Genetic Diseases														
Stroke														
Substance Abuse														
Thyroid Disorders														
Smoking														
Tuberculosis														
Other: _____														

SOCIAL HISTORY:

Tobacco Use: Please list the types of tobacco products you have or currently use (cigarette, pipe, cigar, chew, etc.), the amount used (# of packs or amount per day), the date or age you started, the date or age you stopped.

Type of Tobacco	Amount or Packs/Day	Date or Age Started	Date or Age Quit

Second Hand Smoke: No Exposure I am exposed to second hand smoke,

Where? _____

Alcohol Use: Please state what type of alcoholic beverages you drink (beer, wine, hard liquor, etc.), the amount per day or week (how frequently you drink it), date/age you started drinking alcohol, date/age you quit. If none, state none. (Example: Beer, 1 six pack per day for 20 years)

Type of Alcohol	Amount per day/wk/month	Date or Age Started	Date or Age Quit

I have had a past alcohol problem I feel I have a present alcohol problem

Have you felt you should cut down on your drinking? Yes No

Have People annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or guilty about drinking? Yes No

Have you ever taken a drink first thing in the morning (Eye Opener) to steady your nerves or get rid of a hangover? Yes No

How many drinks does it take to feel high? _____

Recreational (Street) Drug Use: Please list any drugs or habit forming substances who have tried or used. State the type or name, how much, how often and when. (Example: marijuana, 3-5 joints per week, from ages 21-25):

Domestic Violence: Have you experienced threats, physical abuse from your partner? Never Past Present

Education/School: Less than 12th High School Grad Trade/Vocational School College Professional

Physical Exercise: Please state, if any, forms of physical exercise you perform. State what it is, how long each time you perform it, how often you perform it per day/wk/month.

Type of Exercise	How Long Each Time	Times per week

Mind-Body Exercise: Prayer Meditation Relaxation Techniques Other: _____

Sources of Support: None Self Spouse/Partner Family Friends Clergy

Hobbies: _____

Sexual Orientation: Heterosexual Homosexual Bisexual

DIET:

Current Usual Diet: There are feeding difficulties or problems, explain:

Water: Glasses per day consumed: _____

Type of water consumed: Tap Distilled Spring Well Bottled in Plastic Bottled in glass
 Fluoridated Filtered

How many meals *per week* are the **following foods** consumed?

White bread/rolls/bagels _____ Milk: _____ Diet Soda _____ Whole Grains _____

Cheese: _____ Soda _____ Chocolate _____ Ice Cream _____ Cups hot

Chocolate _____ Candy _____ Vegetables _____ Cups tea with caffeine _____

Fast food meals _____ Salty Food _____ Cups tea without caffeine _____

What type of **sweetener** is used: White Sugar Artificial Sweetener Honey Molasses Stevia Other: _____

What type of **cooking oil** is used: Vegetable Oil Canola Oil Olive Oil Lard Crisco Pam Other: _____

Do you use: Margarine Butter

Types of **fruits and vegetables** eaten? Fresh Frozen Canned Organic without insecticides

Seven Day Food Dairy Intake: Please list everything you eat and drink for 7 days or as many as you can before your appointment.

Day	Breakfast	Lunch	Dinner	Snacks
EX	Coffee, 2 cups w/cream, sugar 2 donuts 8 oz. Glass milk	Big Mac Large French Fry 32 oz. Pepsi Salad w/dressing 1 can Pepsi mid - afternoon	1 soy burger Brown Rice Fresh green beans Olive oil on green beans	1 bag Doritos 5 sticks gum 1 bag popcorn 8 oz. Water-tap water 8 oz. Water-spring
1				
2				
3				
4				
5				
6				
7				