PATIENT INTAKE

Today’s Date:

**Legal Name:­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Age:­­\_\_\_\_\_ Birthdate:­­\_\_\_\_/\_\_\_\_/\_\_\_\_\_ Height:\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_

Relationship Status: partnered single married divorced

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell/Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Name and Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Insurance Address & Policy Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Reason For This Visit**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did this problem begin?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis by an MD?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lab Results for the above Characteristics? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_What makes it feel better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What other forms of treatment have you sought? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous/Present Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other practitioners involved in your care (please list, including specialty):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Past Medical History (Please List or Describe, Year/Date):**

Operations or Surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Accidents:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Broken Bones:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalizations:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Serious Illnesses:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Transfusions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pacemakers:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications, Allergies, and Sensitivities**

Please list any medications or drugs, and any foods or substances to which you are **allergic:**

**Are you or have you been exposed to any of the following?**  Chemicals\_\_\_\_ radiation\_\_\_\_ paints\_\_\_\_ fumes\_\_\_\_ dust\_\_\_\_ solvents\_\_\_\_ unpurified water\_\_\_\_ Travel to 3rd world country\_\_\_\_ wilderness areas\_\_\_\_ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Number of courses of antibiotics: Less than 5\_\_\_\_ 5-10\_\_\_\_ More than 10\_\_\_\_
Courses of steroids (how many): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List all medications you are taking (including over-the-counter meds and birth control pills – past or current):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**List any vitamins, herbs, or supplements you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY History
Please list the health of your family members as Excellent, Good, Fair, or Poor.** Indicate if they have any of the following: allergies or asthma, anemia, arthritis, bleeding tendencies, cancer or tumor, colitis, depression, diabetes, drug or alcohol abuse, epilepsy, glaucoma, heart disease, high blood pressure, immunologic disease, kidney or bladder trouble, liver disease, mental illness, migraines, obesity, osteoporosis, stomach issues, stroke, TB, other. If deceased, please list the cause and at what age they passed.

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brothers/Sisters (please indicate sex): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children (please indicate sex): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grandparents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Relatives: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Habits (circle Yes or No and circle Day or Week)** Tobacco Smoking: Yes No \_\_\_\_ packs per day/week Type of Tobacco\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coffee Yes No \_\_\_\_cups per day/week Regular\_\_\_\_\_ Decaf\_\_\_\_\_\_\_\_\_\_\_\_ Tea Yes No \_\_\_\_cups per day/week Regular\_\_\_\_\_ Herbal\_\_\_\_\_\_\_\_\_\_\_ Alcohol Yes No \_\_\_\_ drinks per day/week Wine\_\_\_\_\_Beer\_\_\_\_\_ Liquor\_\_\_\_\_ Soft Drinks Yes No \_\_\_\_ drinks per day/week Regular\_\_\_\_ Diet \_\_\_\_\_\_ Artificial Sweeteners Yes No \_\_\_\_packs per day/week Glasses water/fluids per day \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Activities/Sleep/Energy** What exercise/activities do you do and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours of sleep per night? \_\_\_\_\_\_­­Is it restful? \_\_\_\_\_\_\_ Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­ Do you have an adequate energy level?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **DIET**  What do you eat? ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any foods you strongly dislike?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How do you feel after meals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cravings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Temperature of food/drinks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Weird tastes in mouth?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thirst?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Liquid consumption? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Skip meals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Notes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SYMPTOMS: Have you ever had any of the following? Please indicate “C” for current and “P” for past:**

**GENERAL**  \_\_\_Fever, chills, sweats \_\_\_ Night sweats
\_\_\_ Fatigue
\_\_\_ Nervousness/anxiety \_\_\_ Irritability \_\_\_ Depression
\_\_\_ Generally feel “run down”
\_\_\_ Sexual abuse (optional)
\_\_\_ Emotional abuse (optional)
\_\_\_ Loss of weight
**SKIN**\_\_\_ Non-healing sore
\_\_\_ Hives, rash
\_\_\_ Eczema, psoriasis
\_\_\_ Frequent infection or boils
\_\_\_ Abnormal pigmentations, moles \_\_\_ Warts
\_\_\_ Herpes: \_\_\_ lips
\_\_\_ genital
\_\_\_ zoster (shingles) \_\_\_ Skin cancer or melanoma \_\_\_ Brittle or weak nails
\_\_\_ Infected nails **ENDOCRINE**  \_\_\_ Diabetes
\_\_\_ Thyroid disease
\_\_\_ Heat or cold intolerance
\_\_\_ Dry skin
\_\_\_ Change in hair growth or texture \_\_\_ Excessive thirst or urination
\_\_\_ Sexual problems
\_\_\_ Hormone therapy
\_\_\_ Low or high sex drive
\_\_\_ Radiation to neck or face area \_\_\_ Low blood sugar **HEAD-EYES-EARS-NOSE-THROAT** \_\_\_ Headache
\_\_\_ sinus (allergy)
\_\_\_ tension
\_\_\_ migraine
\_\_\_ Head feels “heavy”
\_\_\_ Loss of memory
\_\_\_ Light-headedness or “spaciness” \_\_\_ Light bothers eyes
\_\_\_ Eye disease or injury
\_\_\_ Blurry vision
\_\_\_ Double vision
\_\_\_ Loss of vision
\_\_\_ Glaucoma, cataracts
\_\_\_ Loss of balance
\_\_\_ Dizziness or vertigo
\_\_\_ Loss of hearing
\_\_\_ Ear disease
\_\_\_ Impaired hearing
\_\_\_ Ringing/buzzing in ears
\_\_\_ Ear pain
\_\_\_ Discharge from ear
\_\_\_ Runny nose or nasal discharge \_\_\_ Nosebleeds
\_\_\_ Chronic sinus trouble \_\_\_ Snoring
\_\_\_ Sore throats
\_\_\_ Hoarseness
\_\_\_ Tooth & gum problems
\_\_\_ Loss of taste
\_\_\_Sores, mouth/tongue **RESPIRATORY**\_\_\_ Frequent “colds”
\_\_\_ Difficulty breathing
\_\_\_ Chronic or frequent cough
\_\_\_ Asthma or wheezing
\_\_\_ Emphysema
\_\_\_ Spitting up blood
\_\_\_ Pleurisy (pain with breathing)
\_\_\_ Pneumonia
\_\_\_ Coughing up sputum

 **CARDIOVASCULAR**\_\_\_ High blood pressure
\_\_\_ Palpitation, irregular heart beat \_\_\_ Rheumatic fever
\_\_\_ Chest pain or angina
\_\_\_ Shortness of breath with walking \_\_\_ Shortness of breath lying down \_\_\_ Difficulty walking two blocks
\_\_\_ Heart trouble
\_\_\_ Heart attack
\_\_\_ Heart murmur
\_\_\_ Awakening in night smothering \_\_\_ Swelling of hands, feet or ankles \_\_\_ Need more than 1 pillow to sleep \_\_\_ Calf pain walking relieved by rest \_\_\_ Varicose veins
**HEMATOLOGIC**\_\_\_ Excessive bleeding/bruising
\_\_\_ Anemia
\_\_\_ Phlebitis/blood clots in veins
\_\_\_ Are you slow to heal after
cuts or bruising?
\_\_\_ Difficulty w/bleeding excessively after tooth extraction or surgery
\_\_\_ Mononucleosis **GASTROINTESTINAL**\_\_\_ Painful bowel movement
\_\_\_ Vomiting blood or food
\_\_\_ Heartburn/indigestion
\_\_\_ Food sticks in throat
\_\_\_ Difficulty swallowing
\_\_\_ Diarrhea or loose stools
\_\_\_ Ulcer (stomach or duodenal)
\_\_\_ Gallbladder disease or stones
\_\_\_ Liver trouble/hepatitis
\_\_\_ Bloody or black stools
\_\_\_ Constipation
\_\_\_ “Nervous” stomach
\_\_\_ Nausea and/or vomiting
\_\_\_ Bloating in stomach after eating \_\_\_ Bloating or gas in lower abdomen \_\_\_ Thin or ribbon-like stools
\_\_\_ Hard/difficult bowel movements **GENITO-URINARY**\_\_\_ Frequent urination
\_\_\_ Involuntary loss of urine \_\_\_ Burning or painful urination \_\_\_ Blood in urine
\_\_\_ Straining to urinate
\_\_\_ Hernia \_\_\_ Sexually transmitted disease \_\_\_ Kidney stones
\_\_\_ Kidney infections
**FEMALE**  \_\_\_ Last menstrual period\_\_\_\_\_date \_\_\_ Currently pregnant
\_\_\_ Age periods started
\_\_\_ Duration of flow \_\_\_\_ days \_\_\_ Days in cycle \_\_\_\_\_\_\_ days \_\_\_ Pelvic pain or infection \_\_\_ Excess discharge
\_\_\_ PMS
\_\_\_ Menstrual cramping
\_\_\_ Irregular cycle
\_\_\_ Number of pregnancies
\_\_\_ Number of children
\_\_\_ Number of ectopic pregnancies \_\_\_ Number of miscarriages
\_\_\_ Number of abortions
\_\_\_ Uterine fibroids
\_\_\_ Hysterectomy
\_\_\_ Date of menopause \_\_\_\_\_\_
\_\_\_ Hot flashes
\_\_\_ Menopausal bleeding
\_\_\_ Breast pain
\_\_\_ Breast lumps
\_\_\_ Nipple discharge or bleeding
\_\_\_ Abnormal PAP smear
**MALE**\_\_\_ Testicular pain/swelling
\_\_\_ Urinary frequency or burning
\_\_\_ Difficulty in starting stream of urine \_\_\_ Discharge from penis
\_\_\_ Frequent night urination
\_\_\_ Prostate pain/swelling
\_\_\_ Undescended testicle
\_\_\_ Impotence **LOCOMOTOR-MUSCULOSKELETAL** \_\_\_ Joint swelling
\_\_\_ Arthritis or joint pain
\_\_\_ Weakness of muscles or joints
\_\_\_ Back pain
\_\_\_ Difficulty walking
\_\_\_ Leg cramps
\_\_\_ Leg ulcers
**MENTAL EMOTIONAL/NEUROLOGIC** \_\_\_ Fainting spells
\_\_\_ Epilepsy/Seizures
\_\_\_ Stroke or mini-stroke
\_\_\_ Paralysis
\_\_\_ Weakness of an arm or leg
\_\_\_ Insomnia or trouble sleeping **Tendency towards:**\_\_\_ Sadness/grief/depression
\_\_\_ Anger/irritability
\_\_\_ Anxiety/fear
\_\_\_ Mental over-activity

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Name**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date**