

Name _____ Date _____

Do you have or have you had in the past, chronic or recent recurring problems with any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Trouble seeing | <input type="checkbox"/> Dizziness/Vertigo |
| <input type="checkbox"/> Blind spots | <input type="checkbox"/> Light-headedness |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Abnormal movements |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Wear contacts/glasses | <input type="checkbox"/> Weakness/Tremors |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Tooth or gum disease | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Sore tongue | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Urinary infections |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Urgency |
| <input type="checkbox"/> Voice change | <input type="checkbox"/> Protein in urine |
| <input type="checkbox"/> History of thyroid disease | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Trouble starting stream |
| <input type="checkbox"/> Cough up phlegm/sputum | <input type="checkbox"/> Urinating at night |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Age at first period |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Interval between periods |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Menopausal (age? ____) |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Previous heart attack | <input type="checkbox"/> Severe cramps |
| <input type="checkbox"/> Heart Failure | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Swelling of ankles | <input type="checkbox"/> Onset of last period (date: ____) |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Cancer: Site: _____ |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Treatment _____ |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Date completed _____ |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Joint pain, swelling |
| <input type="checkbox"/> Food intolerances | <input type="checkbox"/> Bone disease |
| <input type="checkbox"/> Jaundice/Gallstones | <input type="checkbox"/> Back trouble |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hair/nail changes |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Heat/cold intolerance |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Vomiting blood | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Emotional difficulties |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Change in skin pigment |
| <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Skin trouble |
| <input type="checkbox"/> Change in bowel habits | <input type="checkbox"/> H1V disease |
| <input type="checkbox"/> Use Laxatives regularly | <input type="checkbox"/> Other STD |
| <input type="checkbox"/> Cirrhosis; Liver disease | |

Diseases:

- Chicken pox
- Measles
- Mumps
- Hepatitis
- Meningitis
- Mononucleosis
- Tuberculosis

How much alcohol do you drink?

- None Once a month
- Daily Once a week

Date of last tetanus shot _____

Date of last Flu shot _____

Hepatitis B shot _____

Do you exercise regularly? _____

Do you sleep well or poorly? _____

Do you feel you are overweight? _____

Do you diet frequently? _____

Do you eat a special diet? _____