ADULT MEDICAL QUESTIONNAIRE

Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of these questions will help us establish an accurate picture of your current state of health and identify any possible underlying causes of illness. Your written responses as well as your thoughtful answers to those posed by the clinician during your consultations will be invaluable information. The more detailed information you can provide the more effective our use of your scheduled consultation time to formulate a tailored treatment plan.

First Name: _____Middle Name: _____Last Name: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____
month day year

Work Phone: (_____) _____-_____

Place of Birth:_____
City or town & country if not US

Occupation: _____

Referred by: _____ Height: ___' ____ " Weight: _____ Sex: _____

Please (√) the appropriate box(es):

☐ Caucasian ☐ African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Pacific Islander ☐ Mixed Race ☐ Other

Today's Date _____

Please check (√) any of the following whose care you are under

☐ Medical doctor (MD) ☐ Psychiatrist/Psychologist ☐ Dentist
☐ Osteopath ☐ Physical Therapist ☐ Chiropractor

Other _____

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, accident, physical, etc.):_____
_____

Describe Your Overall General Health: _____
_____
_____

ADULT MEDICAL QUESTIONNAIRE

1. Please list current and ongoing symptoms in order of priority and fill in ALL columns as completely as possible:

DESCRIBE MAJOR COMPLAINTS/SYMPTOMS	**RATE SYMPTOM SEVERITY ON SCALE FROM 1 TO 10 (10 being the most severe)**	**EXISTING TREATMENT APPROACH (state 'none' if no current treatment)**	**CURRENT TREATMENT SUCCESS (if applicable)**
Example: Post Nasal Drip	5	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

What is the main reason (from the complaints listed above) that prompted you to seek help?_____
_____

How long does this last? How often do you have this (these) symptom(s)?_____
_____

What aggravates this (these) symptom(s)_____
_____

What makes this (these) symptom(s) better? _____
_____

Please describe symptoms if they were not detailed in the major complaint area above_____
_____

Family History

CONDITION	FAMILY MEMBER	CONDITION	FAMILY MEMBER
☐ Allergies (including food allergies)		☐ Stomach or Duodenal Ulcer	
☐ Fibromyalgia/ Chronic Fatigue		☐ High Cholesterol/ Triglycerides	
☐ Digestive Disease/ Disorder		☐ Multiple Sclerosis (Autoimmune)	
☐ Environmental Sensitivities		☐ Gallbladder Disorders (e.g. gallstones)	
☐ Alzheimer's/Dementia		☐ Asthma	
☐ Anemia		☐ Liver Disease/ Hepatitis	
☐ Anorexia		☐ Diabetes	
☐ Depression		☐ Mental Illness	
☐ Alcoholism/Drug Use		☐ Eating Disorder	
☐ Glaucoma		☐ Migraine Headaches	
☐ Stroke		☐ Cancer or Tumor	
☐ Obesity		☐ Thyroid Disease	
☐ Autoimmune Disorders		☐ Blood Clotting Problems	
☐ Chemical Sensitivities		☐ Autism	
☐ HIV, AIDS		☐ Frequent Infections	

Is there any other family history we should know about (that was not listed above)? ☐ Yes ☐ No
If so, please comment:

_____

_____

Social History

With whom do you live? Please list all children, parents, relatives, friends, and their ages.
Example: Wendy, age 7, sister

_____
_____

Do you have any pets or farm animals? ☐ Yes ☐ No
If yes, where do they live? ☐ Indoors ☐ Outdoors ☐ Both Indoors and Outdoors

Have you lived or traveled outside of the United States? ☐ Yes ☐ No
If so, when, and where?

_____
_____

Have you experienced any major losses in life? ☐ Yes ☐ No
If so, please comment:

_____
_____

Have you or your family recently experienced any major life changes? ☐ Yes ☐ No
If yes, please comment:

_____
_____

How important is religion (or spirituality) for you and your family's life?
☐ not at all important ☐ somewhat important ☐ extremely important

Please list all previous
jobs:_____
_____

How much time have you lost from work or school in the past year?
☐ 0-2 days ☐ 3 –14 days ☐ > 15 days

What type of schooling have you been through or are in the process of going
through?_____
_____

Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe in telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

a. Did you feel safe growing up?	☐ Yes	☐ No
b. Have you been involved in abusive relationships in your life?	☐ Yes	☐ No
c. Was alcoholism or substance abuse present in your childhood home?	☐ Yes	☐ No
d. Is alcoholism or substance abuse present now in your relationships?	☐ Yes	☐ No
e. Do you currently feel safe in your home?	☐ Yes	☐ No

Past Medical and Surgical History

Please indicate (√) next to conditions/procedures relevant to you.

(√)	ILLNESSES	WHEN	COMMENTS
	Anemia		
	Arthritis		
	Asthma		
	Bronchitis		
	Cancer		
	Chronic Fatigue Syndrome		
	Crohn's Disease or Ulcerative Colitis		
	Diabetes		
	Emphysema		
	Epilepsy, convulsions, or seizures		
	Gallstones		
	Gout		
	Heart attack/Angina		
	Heart Disease		
	Heart failure		
	Hepatitis		
	Herpes		
	High blood fats (cholesterol, triglycerides)		
	High blood pressure (hypertension)		
	HIV		
	Hypoglycemia		
	Irritable bowel		
	Kidney stones		
	Lyme Disease		
	Mononucleosis		
	Pneumonia		
	Rheumatic fever		
	Sinusitis		
	Sleep apnea		
	Stroke		
	Thyroid disease		
	Other (describe)		
	Back injury		
	Broken (describe)		
	Dislocation		
	Head injury		

(√)	ILLNESSES	WHEN	COMMENTS
	Neck injury		
	Sprain		
	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
	Barium Enema		
	Blood Work		
	Bone Scan		
	CAT Scan of Abdomen		
	CAT Scan of Brain		
	CAT Scan of Spine		
	Chest X-ray		
	Colonoscopy		
	EKG		
	Liver scan		
	Neck X-ray		
	NMR/MRI		
	Sigmoidoscopy		
	Upper GI Series		
	Other (describe)		

Operations:

	OPERATIONS	WHEN	COMMENTS
	Appendectomy		
	Dental Surgery		
	Gall Bladder		
	Hernia		
	Hysterectomy		
	Tonsillectomy		
	Other (describe)		

Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON

Please indicate (√) how often you have taken antibiotics.

	Over 5 Times	Less Than 5 Times
Infancy/ Childhood		
Teen		
Adulthood		

Please indicate (√) how often you have taken oral steroids (e.g., Cortisone, Prednisone, etc.).

	Over 5 Times	Less Than 5 Times
Infancy/ Childhood		
Teen		
Adulthood		

Please list the medications you are currently taking. Include both prescription and over-the-counter.

Medication Name	Date started	Dosage	How Often?	Consistently?
1.			Times/day	
2.			Times/day	
3.			Times/day	
4.			Times/day	
5.			Times/day	
6.			Times/day	
7.			Times/day	
8.			Times/day	

Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list: _____

List all vitamins, minerals, and other nutritional supplements that you are taking. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Herbal Supplement	Date started	Dosage	Form of Vitamin/Mineral	How Often?
1.				Time/day
2.				Time/day
3.				Time/day
4.				Time/day
5.				Time/day
6.				Time/day
7.				Time/day
8.				Time/day

Childhood:

	Yes	No	Don't Know	Comment
Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
As a child did you eat a lot of sugar and/or candy?				

As a child, were there any foods that you had to avoid because they gave you symptoms? ☐ Yes ☐ No
If yes, please: name the food and symptom (Example: milk – gas and diarrhea)_____
_____
_____

Diet

Indicate (√) the foods/drinks that apply to your current diet.

√	USUAL BREAKFAST	√	USUAL LUNCH	√	USUAL DINNER
	None		None		None
	Bacon/Sausage		Butter		Beans (legumes)
	Bagel		Coffee		Brown rice
	Butter		Eat in a cafeteria		Butter
	Cereal		Eat in restaurant		Carrots
	Coffee		Fish sandwich		Coffee
	Donut		Juice		Fish
	Eggs		Leftovers		Green vegetables
	Fruit		Lettuce		Juice
	Juice		Margarine		Margarine
	Margarine		Mayo		Milk
	Milk		Meat sandwich		Pasta
	Oat bran		Milk		Potato
	Sugar		Salad		Poultry
	Sweet roll		Salad dressing		Red meat
	Sweetener		Soda		Rice
	Tea		Soup		Salad
	Toast		Sugar		Salad dressing
	Water		Sweetener		Soda
	Wheat bran		Tea		Sugar
	Yogurt		Tomato		Sweetener
	Other: (List below)		Water		Tea
			Yogurt		Water
			Other: (List below)		Yellow vegetables
					Other: (List below)

How many glasses of water do you drink during a typical day? _____

How often do you choose organic fruits and vegetables and grass-fed/cage-free animal products?

_____

How many meals do you consume each day? _____ What is the time interval between each meal?_____

Indicate when you snack:

Between Meals ☐ Yes ☐ No

Before Bedtime ☐ Yes ☐ No

If yes, what do you normally eat?_____

_____

How much of the following do you consume each week?

a.	Hard and Sugar Candy (pieces)	
b.	Cheese (oz, where 1 oz = size of a dice)	
c.	Chocolate (oz)	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Cups of Diet sodas	
i.	Cups of Sodas with caffeine	
j.	Cups of Sodas without caffeine	
k.	Slices of white bread (or rolls/bagels)	
l.	Ice cream (cups)	
m.	Chips and Crackers (cups)	

Are you on a special diet? ☐ Yes ☐ No

☐ ovo-lacto ☐ vegetarian ☐ other (describe):

☐ dietary restricted ☐ vegan _____

☐ diabetic ☐ blood type diet _____

Are you injecting insulin? ☐ Yes ☐ No

If yes, how often? _____ How much? _____

Is there anything special about your diet that we should know? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Do you have symptoms **immediately after** eating, such as belching, bloating, sneezing, hives, etc.?

☐ Yes ☐ No

If yes, are these symptoms associated with any particular food or supplement(s)?

☐ Yes ☐ No

If yes, please name the food or supplement and symptom(s). (Example: Milk – gas and diarrhea)_____

_____

Do you feel you have **delayed** symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? ☐ Yes ☐ No

ADULT MEDICAL QUESTIONNAIRE

Do you feel significantly **worse** when you eat a lot of :

- ☐ high fat foods
- ☐ high protein foods
- ☐ high carbohydrate foods (breads, pastas, potatoes)
- ☐ refined sugar (junk food)
- ☐ fried foods
- ☐ 1 or 2 alcoholic drinks
- ☐ other _____

Do you feel significantly **better** when you eat a lot of :

- ☐ high fat foods
- ☐ high protein foods
- ☐ high carbohydrate foods (breads, pastas, potatoes)
- ☐ refined sugar (junk food)
- ☐ fried foods
- ☐ 1 or 2 alcoholic drinks
- other _____

Does skipping a meal greatly affect your symptoms? ☐ Yes ☐ No

Have you ever had a food that you craved or really "binged" on over a period of time? ☐ Yes ☐ No
If yes, what food(s)? _____
_____

Do you have an aversion to certain foods? ☐ Yes ☐ No
If yes, what food(s)? _____
_____

Do you have trouble eating because of loose, ill fitting, or missing teeth? ☐ Yes ☐ No

Do you prepare the meals eaten in your house? ☐ Yes ☐ No
If no, who does?_____

Check All That Describe Your Eating Habits:

- ☐ I eat-out at restaurants _____ times a week.
- ☐ Emotional eating
- ☐ Don't know what to eat
- ☐ Chocolate is my weakness.
- ☐ Hate to exercise
- ☐ Meal Planning
- ☐ Self Esteem
- ☐ Family Influences and Peers
- ☐ Work is my downfall
- ☐ Parties and Social Events
- ☐ Lack of Focus
- ☐ Hunger
- ☐ Habits or Patterns
- ☐ Comfort Foods
- ☐ Snacking, Grazing and Nibbling
- ☐ Too Busy
- ☐ I binge eat _____ times a week, _____ times a month.
- ☐ No time to eat regularly.
- ☐ I love food and it loves me.
- ☐ Loss of Energy at certain times of the day.
- ☐ Don't know how to exercise
- ☐ I don't have the money to eat healthy
- ☐ Picky Eater
- ☐ Negative Self Talk
- ☐ Home is my downfall
- ☐ Medical Reasons
- ☐ Motivation
- ☐ Cravings
- ☐ Tradition and genetics are my challenge.
- ☐ Unconscious Eating
- ☐ Too Tired

Bowl Movements

Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Contains undigested food			
Alternating between hard and loose/watery			

Indicate **(√)** how often you experience intestinal gas:

- ☐ Daily
- ☐ Occasionally
- ☐ Excessive
- ☐ Present with pain
- ☐ Foul smelling
- ☐ Little odor

Drugs/Alcohol

Have you ever used alcohol? ☐ Yes ☐ No

If yes, how often do you now drink alcohol?

- ☐ No longer drinking alcohol
- ☐ Average 1-3 drinks per week
- ☐ Average 4-6 drinks per week
- ☐ Average 7-10 drinks per week
- ☐ Average >10 drinks per week

c. Have you ever had a problem with alcohol? ☐ Yes ☐ No

d. If yes, please indicate time period (month/year): From _____ To _____.

Have you ever used recreational drugs? ☐ Yes ☐ No

Have you ever used tobacco? ☐ Yes ☐ No

If yes, number of years as a nicotine user _____ Amount per day _____ Year quit _____

If yes, what type of nicotine have you used?

- ☐ Cigarette
- ☐ Smokeless
- ☐ Cigar
- ☐ Pipe
- ☐ Patch/Gum

Are you exposed to second hand smoke regularly? ☐ Yes ☐ No

Toxin Exposure

Do you have mercury amalgam fillings? ☐ Yes ☐ No
Do you have any artificial joints or implants? ☐ Yes ☐ No
Do you feel worse at certain times of the year? ☐ Yes ☐ No
If yes, when? ☐ spring ☐ fall
☐ summer ☐ winter

Have you, to your knowledge, been exposed to toxic metals in your job or at home? ☐ Yes ☐ No
If yes, which one(s)? ☐ lead ☐ cadmium
☐ arsenic ☐ mercury
☐ aluminum

Do odors affect you? ☐ Yes ☐ No

Social/Mental Status

Please indicate (√) how well things have been going for you:

	VERY WELL	FAIR	POORLY	VERY POORLY	DOES NOT APPLY
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

Have you ever had psychotherapy or counseling? ☐ Yes ☐ No
☐ Currently? ☐ Previously? If previously, from _____ to _____
What kind?
_____
Comments:
_____
_____

Are you currently, or have you ever been, married? ☐ Yes ☐ No
If so, when were you married? _____ Spouse's occupation _____
When were you separated? _____ Never _____
When were you divorced? _____ Never _____
When were you remarried? _____ Never _____

Comments:_____
_____

What is the attitude of those close to you about your illness?

- ☐ Supportive
- ☐ Non-supportive

Have you ever experienced forgetfulness/slow mental process?_____

Have you experienced difficulty concentrating?

_____

See Appendix A: Quality of Life Assessment for further evaluation.

Physical Activity

Hobbies and leisure activities:_____

_____

Do you exercise regularly? ☐ Yes ☐ No

If so, how many times a week?

- ☐ 1x
- ☐ 2x
- ☐ 3x
- ☐ 4x or more

When you exercise, how long is each session?

- ☐ <15 min
- ☐ 16-30 min
- ☐ 31-45 min
- ☐ 45 min

What type of exercise is it?

- ☐ jogging/walking
- ☐ basketball
- ☐ home aerobics
- ☐ tennis
- ☐ water sports

other _____

How long have you been exercising regularly?_____

How long does it take you to recover after exercise?_____

Occupational Activity Level (Please "(√)" One:

- ☐ Sedentary: Sitting
- ☐ Light: Standing
- ☐ Moderate: Walking
- ☐ Active: Manual Labor

*****See Appendix B: Physical Activity Questionnaire for further evaluation***

Current Symptoms

Please check if these symptoms either occur presently **or** have occurred in the past 6 months.

GENERAL:	Mild	Mod.	Severe
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
Numb fingers and toes			
No dream recall			
Sensitive to minor changes in weather			
Tired, sluggish			
Unintentional weight loss			

HEAD, EYES, NOSE & EARS:	Mild	Mod.	Severe
Burning of eyes			
Conjunctivitis			
Discharge from eyes			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			

HEAD, EYES, NOSE & EARS CONT'D:	Mild	Mod.	Severe
Hearing problems			
Lid margin redness			
Migraine			
Nasal congestion or discharge			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	Mild	Mod.	Severe
Abdominal cramps, aches			
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
Tight sensation in neck			
TMJ problems			

MOOD/NERVES:	Mild	Mod.	Severe
Agoraphobia			

Anxiety			
Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			
Unsteady gait			
Mood swings			
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Restless, agitated, angry			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			

EATING:	**Mild**	**Mod.**	**Severe**
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
EATING CONT'D:	**Mild**	**Mod.**	**Severe**
Feeling hungry an hour or two after eating			
Poor appetite			
Sense of fullness during and after meals			
Salt craving			

DIGESTION:	**Mild**	**Mod.**	**Severe**
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of: Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			
Bowl Pain			
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Indigestion			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
DIGESTION CONT'D:	**Mild**	**Mod.**	**Severe**
Liver disease/jaundice (yellow eyes or skin)			

Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Smooth tongue			
Sore tongue			
Sores in corner of mouth			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			

GENERAL SKIN PROBLEMS:	**Mild**	**Mod.**	**Severe**
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Blotchy skin			
Bruising easily			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			
Skin in general			
Throat			
Scalp			
Eczema			
Elasticity lost			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Moles w color/size change			
GENERAL SKIN PROBLEMS CONT'D:	**Mild**	**Mod.**	**Severe**
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Puffy face, hands, and feet			
Rash			
Red face			
Open sores on feet and legs			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Swollen eyelids			
Thick calluses			
Vitiligo			

SKIN, ITCHING:	**Mild**	**Mod.**	**Severe**
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			

SKIN, DRYNESS OF:	**Mild**	**Mod.**	**Severe**
Eyes			
Feet			
Any cracking?			
Any peeling?			
SKIN, DRYNESS OF CONT'D:	**Mild**	**Mod.**	**Severe**
Hair			

Unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			

HAIR:	**Mild**	**Mod.**	**Severe**
Loss of chest and armpit hair			
Loss of eyebrow hair (lateral 1/3)			
Loss of lower leg hair			

LYMPH NODES:	**Mild**	**Mod.**	**Severe**
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			

NAILS:	**Mild**	**Mod.**	**Severe**
Bitten			
Brittle			
Curve up			
Discolorations			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Finger nails			
NAILS CONT'D:	**Mild**	**Mod.**	**Severe**
Toenails			
White spots/lines			

RESPIRATORY:	**Mild**	**Mod.**	**Severe**
Bad breath			
Bad odor in nose			
Chest pain			
Cough - dry			
Cough - productive			
Difficulty breathing			
Hay fever : Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			

CARDIOVASCULAR:	**Mild**	**Mod.**	**Severe**
Angina/chest pain			
Breathlessness			
Heart attack			
Heart burn			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Phlebitis			
Pounding heart			
CARDIOVASCULAR CONT'D:	**Mild**	**Mod.**	**Severe**
Swollen ankles/feet			

Varicose veins			
Slow heartbeat			

URINARY:	**Mild**	**Mod.**	**Severe**
Bed wetting			
Dark Urine			
Hesitancy			
Increased frequency			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			

MALE REPRODUCTIVE:	**Mild**	**Mod.**	**Severe**
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			

FEMALE REPRODUCTIVE:	**Mild**	**Mod.**	**Severe**
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			
<u>Premenstrual:</u> Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
<u>Menstrual</u>: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

For Women Only **(questions 50-58):**

2. Have you ever been pregnant? (If no, skip to question 53.) ☐ Yes ☐ No

   Number of miscarriages _____ Number of abortions _____ Number of preemies _____

   Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

   Did you develop toxemia (high blood pressure)? ☐ Yes ☐ No

   Have you had other problems with pregnancy? ☐ Yes ☐ No

   If so, please comment: _____
   _____

3. Age at first period _____ Date of last Pap Smear _____ Date of last Mammogram_____

   Pap Smear: ☐ Normal ☐ Abnormal
   Mammogram: ☐ Normal ☐ Abnormal

   In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? ☐ Yes ☐ No ☐ Not applicable

4. Have you ever used birth control pills? ☐ Yes ☐ No If yes, when _____

5. Are you taking the pill now? ☐ Yes ☐ No

6. Did taking the pill agree with you? ☐ Yes ☐ No ☐ Not applicable

7. Do you currently use contraception? ☐ Yes ☐ No
   If yes, what type of contraception do you use? _____

8. Are you in menopause? ☐ Yes ☐ No If yes, age at last period_____
   Do you take: ☐ Estrogen ☐ Ogen ☐ Estrace ☐ Premarin
   ☐ Progesterone ☐ Provera Other (specify) _____

How long have you been on hormone replacement therapy (if applicable)? _____

Do you have any other concerns or questions that have not been addressed in this form? Anything I need to know about your case history that was not covered on this form?

_____
_____

_____ Date_____
Patient Signature

Appendix A: Quality of Life Assessment

Appendix B: Physical Activity Questionnaire