Your Lifestyle:

☐ Alcohol ☐ Marijuana ☐ Stress
☐ Tobacco ☐ Drugs ☐ Occupational hazards

Regular Exercise
Type_______________ Frequency__________
Type_______________ Frequency__________

General Symptoms:

☐ Poor appetite	☐ Poor sleep	☐ Bodily heaviness	☐ Chills	☐ Bleed or bruise easily
☐ Heavy appetite	☐ Heavy sleep	☐ Cold hands or feet	☐ Night sweats	☐ Peculiar taste (Describe)
☐ Like cold drinks	☐ Dream-disturbed sleep	☐ Poor circulation	☐ Sweat easily	____________________________
☐ Like hot drinks	☐ Fatigue	☐ Shortness of breath	☐ Muscle cramps	____________________________
☐ Weight loss/gain	☐ Lack of strength	☐ Fever	☐ Vertigo/dizziness	____________________________

Head, Eyes, Ears, Nose, Throat

☐ Glasses (age?)	☐ Night blindness	☐ Gum problems	☐ Recurrent sore throat	☐ Headaches
☐ Eye strain	☐ Myopia/Presbyopia	☐ Sores on lips/tongue	☐ Swollen glands	☐ Migraines
☐ Eye pain	☐ Glaucoma	☐ Dry mouth	☐ Lumps in throat	☐ Concussions
☐ Red eyes	☐ Cataracts	☐ Excessive saliva	☐ Enlarged thyroid	Other head or neck problems
☐ Itchy eyes	☐ Teeth problems	☐ Sinus problems	☐ Nosebleeds	____________________________
☐ Spots in eyes	☐ Grinding teeth	☐ Excessive phlegm	☐ Ringing in ears	____________________________
☐ Poor vision	☐ TMJ	Color:	☐ Poor hearing	____________________________
☐ Blurred vision	☐ Facial pain		☐ Earaches	

Respiratory

☐ Difficulty breathing wh lying down	☐ Tight chest	☐ Cough	☐ Color of phlegm:	☐ Coughing up blood
	☐ Asthma/wheezing	Wet or Dry? _____	________________________	☐ Pneumonia
☐ Shortness of Breath	☐ Difficult inhale? Exhale?	Thick or thin? _____		

Cardiovascular

☐ High blood pressure	☐ Low blood pressure	☐ Chest pain	☐ Tachycardia	☐ Phlebitis
☐ Blood clots	☐ Fainting	☐ Difficulty breathing	☐ Heart palpitations	☐ Irregular heartbeat/ Afib

Gastrointestinal

☐ Nausea	☐ Diarrhea	☐ Intestinal pain/cramps	Bowel movements:	
☐ Vomiting	☐ Constipation	☐ Burning anus		
☐ Acid regurgitation	☐ Black stools	☐ Rectal pain	Frequency_____________	Texture/form___________________
☐ Gas	☐ Bloody stools	☐ Anal fissures		
☐ Hiccup	☐ Mucous in stools	☐ Laxative use	Color_________________	Odor___________________________
☐ Bloating	☐ Hemorrhoid	What kind?		
☐ Bad breath	☐ Itchy anus	How often?		

Musculoskeletal

☐ Neck/shoulder pain	☐ Upper back pain	☐ Joint pain	☐ Limited range of motion	☐ Other
☐ Muscle pain	☐ Low back pain	☐ Rib pain	☐ Limited use	___________________

Skin and Hair

☐ Rashes	☐ Eczema	☐ Dandruff	☐ Change in hair/skin texture	Other (Specify)
☐ Hives	☐ Psoriasis	☐ Itching	☐ Fungal infections	___________________
☐ Ulcerations	☐ Acne	☐ Hair Loss		___________________

Neuropsychological

☐ Seizures	☐ Poor memory	☐ Irritability	☐ Considered/attempted suicide	Other (Specify)
☐ Numbness	☐ Depression	☐ Easily sressed		___________________
☐ Tics	☐ Anxiety	☐ Abuse survivor	☐ Seeing a therapist	___________________

Genitourinary

☐ Pain on urination	☐ Blood in urine	☐ Venereal disease	☐ Increased libido	☐ Impotence
☐ Frequent urination	☐ Unable to hold urine	☐ Bedwetting	☐ Decreased libido	☐ Premature ejaculation
☐ Urgent urination	☐ Incomplete urination	☐ Wake to urinate	☐ Kidney stone	☐ Nocturnal emission

Gynecology

☐ Age menses began	☐ Duration of flow	☐ Vaginal discharge	☐ Breast lumps	Date of last PAP
_________________	________ days	(color)________________	# Pregnancies_________	__________________________
Length of cycle (day 1-day 1)	☐ Irregular periods	☐ Vaginal sores	# Live births_______	Date last period began
_________________	☐ Painful periods	☐ Vaginal odor	# Premature births______	__________________________
	☐ PMS	☐ Clots	Age at menopause______	