

Headache on:
 Front Temple Side
 Back Top

Dizziness Y N

Fainting Y N

Blurred Vision Y N

Eye Pain Y N

Tinnitus Y N HI LO

Hearing loss Y N

Trouble swallowing Y N

Dry Mouth/Throat Y N

Thirst HI NORM LO

Bleeding Gums Y N

Chest Pressure/Pain Y N

Blood Pressure HI LO

Palpitations Y N

Trouble breathing Y N

Cough Y N
 With blood Y N

Phlegm Y N

Color_____

Frequent colds Y N

Breast Pain Y N

Breast Discharge Y N

Breast Lump Y N

Upper/Lower
 Abdomen Pain Y N

Gas/Bloating Y N

Nausea/Vomiting Y N

Heartburn/Reflux Y N

Increase/ Decrease in
 Hunger Y N

Diarrhea Y N

Constipation Y N

Stools per day _____

Incontinence Y N

Urinary Pain Y N

Frequent urination Y N

Blood in urine Y N

Blood in stool Y N

Libido HI NORM LO

Fever Y N

Hives/Rash Y N

Unexplained weight
 loss/ gain Y N

Insomnia Y N

New/change in mole
 Y N

Swollen glands Y N

Abnormal Sweat Y N

Prefer HOT COLD

Fatigue/weakness Y N

Easy bruising Y N

Anxiety Y N

Depression Y N

Considered/Attempted
 Suicide Y N

What emotion do you
 feel most:

Anger Sadness Worry
 Fear Hyper/Mania

MEN

Testicular Pain Y N

Testicular Mass Y N

Penis Discharge Y N

Genital Sores Y N

Difficult erection Y N

Premature Ejaculation
 Y N

Hernias Y N

WOMEN

Pregnant Now Y N

of Pregnancies _____

of Children _____

Age of first period ____

Age of Menopause ____

Date of Last Period_____

Regular Cycle Y N

Cycle Length _____

Avg Days of Flow ____

Abnorm Bleeding Y N

Flow HI NORM LO

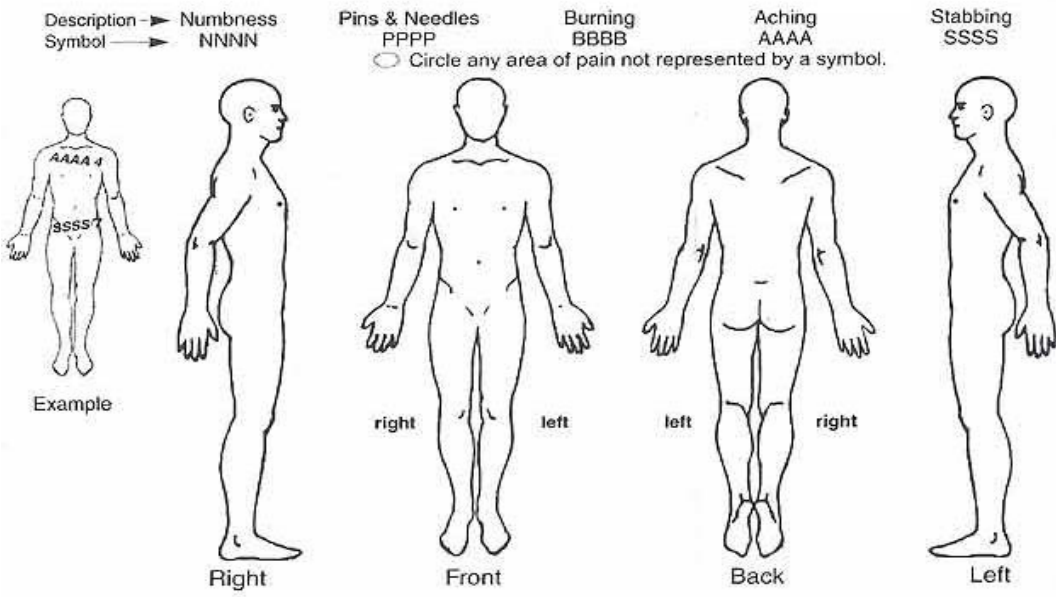
Color _____

Vag. Discharge Y N

Genital sores Y N

Contraception Y N
 ____yrs

Type _____



If you have any conditions I have not asked
 about or you need to explain something
 more in detail please use this space:

Joint Pain Y N

Joint Swelling Y N

Joint Stiffness Y N

Numbness Y N

Weakness Y N

Hot/Cold Limbs Y N

Swollen Limbs Y N

Cramping Y N

_____ Date