

Medical History Form



Please note: If you need more space for any answers on this form, please use the last page.

Date _____

Name _____ Age _____ Birthdate _____ Sex _____

Address _____ City _____

State _____ Zip code _____ Telephone (home) _____ (work) _____

Occupation _____ Education _____

Full time Part time Unemployed Disabled Retired

Members of Household _____ Age/Date of birth _____ Relationship _____

What pets do you have?

What are your most important health care problems? Please list in order of importance to you

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Have you had any of the following medical conditions (please check)

	NOW	PAST		NOW	PAST	
<input type="checkbox"/> AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Migraines/Headaches
<input type="checkbox"/> Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Nervous breakdown
<input type="checkbox"/> Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Obesity
<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Polio
<input type="checkbox"/> Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tumors
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Typhoid
<input type="checkbox"/> Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Worms

Trauma history List any abuse, major accidents, head injuries, falls, blows, etc.

Any loss of consciousness? yes no Please describe:

Hospitalizations

ILLNESSES/INPATIENT OR OUTPATIENT SURGERY

DATE

Any history of animal bites?

List of current prescription medications

Any history of allergic reaction to medications?

List of any current or previous homeopathic remedies

List of current vitamins and supplements

List of any other current medical or health treatments (e.g. acupuncture, massage, dental)

Check any of the following that you use. How much of each and for how long?

- Coffee Marijuana Sleeping pills
- Tea Recreational drugs Thyroid replacement
- Cigarettes/cigars Aspirin Hormone replacement
- Snuff/chewing tobacco Tylenol Birth control pills
- Soft drinks Ibuprofen Chinese herbs
- Alcohol Laxatives Herbs

Do you use an electric blanket? yes no

Do you get regular exercise? yes no If so, what kind?

Any special diet?

FAMILY HISTORY

RELATION	LIVING	DEAD	AGE	MAJOR ILLNESSES OR CAUSE OF DEATH
Mother	<input type="checkbox"/>	<input type="checkbox"/>		
Father	<input type="checkbox"/>	<input type="checkbox"/>		
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
	<input type="checkbox"/>	<input type="checkbox"/>		
Maternal grandmother	<input type="checkbox"/>	<input type="checkbox"/>		
Maternal grandfather	<input type="checkbox"/>	<input type="checkbox"/>		
Paternal grandmother	<input type="checkbox"/>	<input type="checkbox"/>		
Paternal grandfather	<input type="checkbox"/>	<input type="checkbox"/>		

Please check any of the following that have occurred in your blood relatives

- Heart disease
- Kidney disease
- Seizures/Epilepsy
- Hypertension
- Thyroid disease
- Diabetes
- Stroke
- Glaucoma
- Mental illness
- Cancer
- Tuberculosis
- Sexually transmitted disease (e.g. syphilis, gonorrhea, AIDS)
- Neurologic disorders
- Suicide
- Depression
- Alcoholism
- Drug abuse

Birth and developmental history

Did your mother have any problems during pregnancy?
 Problems during labor and delivery?
 Was there any delay in your walking or talking?
 Was there any prolonged bed-wetting?

Childhood illnesses (please check all you've had)

- Rubella
- Rheumatic fever
- Measles
- Mumps
- Whooping cough
- Chickenpox
- Scarlet fever
- Polio

Immunization history (please check all you've had)

- DPT
- Measles/Mumps/Rubella
- Smallpox
- TB
- Pneumovax
- Hepatitis
- Polio
- Flu

Did you have any bad reactions or chronic illnesses following immunizations? yes no
 If so, what?

Please list your hobbies and interests

Favorite books

Favorite movies

Mental symptoms Check any symptoms that are strong, chronic or feel significant to you:

NOW	PAST	NOW	PAST	
<input type="checkbox"/>	<input type="checkbox"/>	Absent minded	<input type="checkbox"/>	Lazy
<input type="checkbox"/>	<input type="checkbox"/>	Angered easily	<input type="checkbox"/>	Lonely
<input type="checkbox"/>	<input type="checkbox"/>	Annoyed by little things	<input type="checkbox"/>	Memory problems
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Mental mistakes (dyslexia, etc.)
<input type="checkbox"/>	<input type="checkbox"/>	Competitive	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Concentration difficult	<input type="checkbox"/>	Nail biting
<input type="checkbox"/>	<input type="checkbox"/>	Consolation desired (when upset)	<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	<input type="checkbox"/>	Consolation not wanted	<input type="checkbox"/>	Nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Critical	<input type="checkbox"/>	Obstinate
<input type="checkbox"/>	<input type="checkbox"/>	Depression/prolonged sadness	<input type="checkbox"/>	Obsessive thinking
<input type="checkbox"/>	<input type="checkbox"/>	Dwelling on past events	<input type="checkbox"/>	Relaxation difficult
<input type="checkbox"/>	<input type="checkbox"/>	Euphoria	<input type="checkbox"/>	Restlessness
<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	Revengeful
<input type="checkbox"/>	<input type="checkbox"/>	Hearing voices	<input type="checkbox"/>	Shy/Timid
<input type="checkbox"/>	<input type="checkbox"/>	Hopeless outlook	<input type="checkbox"/>	Sloppy, messy
<input type="checkbox"/>	<input type="checkbox"/>	Hurried/Hyperactive	<input type="checkbox"/>	Startle easily
<input type="checkbox"/>	<input type="checkbox"/>	Impatient	<input type="checkbox"/>	Suicidal
<input type="checkbox"/>	<input type="checkbox"/>	Increased irritability	<input type="checkbox"/>	Suspicious
<input type="checkbox"/>	<input type="checkbox"/>	Indecisive	<input type="checkbox"/>	Temper
<input type="checkbox"/>	<input type="checkbox"/>	Indifferent/apathetic	<input type="checkbox"/>	Tidy, fastidious
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	Weep easily/frequently
<input type="checkbox"/>	<input type="checkbox"/>	Jealousy	<input type="checkbox"/>	Worry, excessive

Fears Please check any significant fears:

<input type="checkbox"/>	accidents	<input type="checkbox"/>	devil	<input type="checkbox"/>	hurting others	<input type="checkbox"/>	rejection
<input type="checkbox"/>	appearing in public (being seen)	<input type="checkbox"/>	injury	<input type="checkbox"/>	robbers	<input type="checkbox"/>	snakes
<input type="checkbox"/>	being alone	<input type="checkbox"/>	disease	<input type="checkbox"/>	spiders	<input type="checkbox"/>	storms
<input type="checkbox"/>	birds	<input type="checkbox"/>	dogs	<input type="checkbox"/>	knives	<input type="checkbox"/>	strangers
<input type="checkbox"/>	blood	<input type="checkbox"/>	failure	<input type="checkbox"/>	mice	<input type="checkbox"/>	sudden noises
<input type="checkbox"/>	bridges	<input type="checkbox"/>	fainting	<input type="checkbox"/>	monsters	<input type="checkbox"/>	suffocation
<input type="checkbox"/>	cancer	<input type="checkbox"/>	flying	<input type="checkbox"/>	narrow places (claustrophobia)	<input type="checkbox"/>	thunderstorms
<input type="checkbox"/>	cats	<input type="checkbox"/>	future	<input type="checkbox"/>	opposite sex	<input type="checkbox"/>	tunnels
<input type="checkbox"/>	crowds	<input type="checkbox"/>	ghosts	<input type="checkbox"/>	health of family	<input type="checkbox"/>	of unknown
<input type="checkbox"/>	dark	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	poverty	<input type="checkbox"/>	violence
<input type="checkbox"/>	death	<input type="checkbox"/>	heart disease	<input type="checkbox"/>	public speaking		
<input type="checkbox"/>	deep water	<input type="checkbox"/>	heights				

Please list any other fears that you have:

Are there experiences in your life that have had a lasting effect on you or from which you've never recovered?

General symptoms: How do you react to the the following conditions? (please check all that apply)

	NOT AFFECTED BY	WORSE FROM	DISLIKE	BETTER FROM	LIKE/PREFER
humidity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
wind	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
draft	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
rain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
fog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
change in temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
change in season	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
summer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
winter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
spring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
autumn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
afternoon nap	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
climbing stairs/hills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
exercise in general	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
touch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
tight clothes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
warm bath/shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
cold bath/shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
full moon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
being near or in the ocean	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
being in the mountains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
music (what types?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Strongly sensitive to (please check all that apply)

<input type="checkbox"/> noise	<input type="checkbox"/> exhaust	<input type="checkbox"/> odors in general
<input type="checkbox"/> dust, mold	<input type="checkbox"/> perfume	<input type="checkbox"/> cigarette smoke
<input type="checkbox"/> getting feet wet	<input type="checkbox"/> pollen	<input type="checkbox"/> other (please specify):

Have you had:

NOW	PAST	NOW	PAST
<input type="checkbox"/>	<input type="checkbox"/>	large weight gains	<input type="checkbox"/> chronic fatigue
<input type="checkbox"/>	<input type="checkbox"/>	large weight losses	<input type="checkbox"/> weakness

Do you have a dip in energy at a regular time every day or night? yes no If so, when?

What time of day do you have your best energy?

Do you have any periodic symptoms that come at regular intervals? yes no

If so, what are they?

Sleep

NOW	PAST	NOW	PAST
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty falling asleep	Favorite sleep position(s)
<input type="checkbox"/>	<input type="checkbox"/>	Jerking on falling asleep	Stay covered during the night?
<input type="checkbox"/>	<input type="checkbox"/>	Interrupted sleep	Stick feet out from covers?
<input type="checkbox"/>	<input type="checkbox"/>	Sleep walking	Wear socks to bed?
<input type="checkbox"/>	<input type="checkbox"/>	Talking in sleep	Feeling on waking in morning
<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth in sleep	Feeling on waking from nap

Dreams Please check any dreams you have had

<input type="checkbox"/> animals	<input type="checkbox"/> desert	<input type="checkbox"/> missing train	<input type="checkbox"/> poison	<input type="checkbox"/> praying
<input type="checkbox"/> cats	<input type="checkbox"/> ocean	<input type="checkbox"/> unprepared	<input type="checkbox"/> intrigue	<input type="checkbox"/> religious
<input type="checkbox"/> dogs	<input type="checkbox"/> rivers	<input type="checkbox"/> grief	<input type="checkbox"/> talking	<input type="checkbox"/> spiritual
<input type="checkbox"/> horses	<input type="checkbox"/> snow	<input type="checkbox"/> weeping	<input type="checkbox"/> singing	<input type="checkbox"/> God
<input type="checkbox"/> insects	<input type="checkbox"/> death	<input type="checkbox"/> vexation	<input type="checkbox"/> dancing	<input type="checkbox"/> house of worship
<input type="checkbox"/> wild animals	<input type="checkbox"/> dead bodies	<input type="checkbox"/> quarrels	<input type="checkbox"/> business	<input type="checkbox"/> remote events
<input type="checkbox"/> worms	<input type="checkbox"/> body parts	<input type="checkbox"/> jealousy	<input type="checkbox"/> money	<input type="checkbox"/> recent events
<input type="checkbox"/> snakes	<input type="checkbox"/> suicide	<input type="checkbox"/> insults	<input type="checkbox"/> day's work	<input type="checkbox"/> future events
<input type="checkbox"/> robbers	<input type="checkbox"/> hunger	<input type="checkbox"/> misfortunes	<input type="checkbox"/> physical work	<input type="checkbox"/> prophetic
<input type="checkbox"/> thieves	<input type="checkbox"/> thirst	<input type="checkbox"/> insecurity	<input type="checkbox"/> vomiting	<input type="checkbox"/> children
<input type="checkbox"/> ghosts	<input type="checkbox"/> eating	<input type="checkbox"/> danger	<input type="checkbox"/> passing stool	<input type="checkbox"/> parties
<input type="checkbox"/> traveling	<input type="checkbox"/> drinking	<input type="checkbox"/> pursuit	<input type="checkbox"/> urinating	<input type="checkbox"/> birth
<input type="checkbox"/> flying	<input type="checkbox"/> foods	<input type="checkbox"/> accidents	<input type="checkbox"/> bleeding	<input type="checkbox"/> weddings
<input type="checkbox"/> swimming	<input type="checkbox"/> fruit	<input type="checkbox"/> falling	<input type="checkbox"/> pain	<input type="checkbox"/> funerals
<input type="checkbox"/> riding/driving	<input type="checkbox"/> fire	<input type="checkbox"/> shooting	<input type="checkbox"/> illness	<input type="checkbox"/> dead relatives
<input type="checkbox"/> drowning	<input type="checkbox"/> lightning	<input type="checkbox"/> rape	<input type="checkbox"/> sickness	<input type="checkbox"/> dead friends
<input type="checkbox"/> houses	<input type="checkbox"/> storms	<input type="checkbox"/> wars	<input type="checkbox"/> mutilation	<input type="checkbox"/> fatigue
<input type="checkbox"/> buildings	<input type="checkbox"/> rain	<input type="checkbox"/> police	<input type="checkbox"/> romantic	<input type="checkbox"/> fearful
<input type="checkbox"/> bridges	<input type="checkbox"/> failure	<input type="checkbox"/> imprisonment	<input type="checkbox"/> erotic	<input type="checkbox"/> anxious
<input type="checkbox"/> trees	<input type="checkbox"/> exams	<input type="checkbox"/> crimes	<input type="checkbox"/> sexual pleasure	<input type="checkbox"/> happy
<input type="checkbox"/> mountains	<input type="checkbox"/> failing efforts	<input type="checkbox"/> murder	<input type="checkbox"/> nakedness	<input type="checkbox"/> ecstatic

Have you had any recurring dreams? If so, please describe

Please elaborate on any dreams that have made a strong impression on you

Perspiration

- | NOW | PAST |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
- Excessive sweating (specify part of body):
- Strong odor of perspiration
- Night sweats

Head symptoms

- | NOW | PAST | NOW | PAST |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Hair loss
- Dandruff
- Heaviness
- Constriction
- Headaches, location:
- Sensitive scalp
- Eruptions
- Aversion to hats
- Marked sweating, location:

Vertigo

- | NOW | PAST | NOW | PAST |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Loss of balance
- Fainting spells
- Dizziness
- Discomfort with heights
- Car/sea/motion sickness

Eye symptoms

- | NOW | PAST | NOW | PAST |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Poor eyesight
- Blindness
- Aversion to sun
- Double vision
- Eye infections
- Itchy eyes
- Sensation of sand in eyes
- Styes
- See halos, spots or lights
- Pain in eyes
- Excessive tearing
- Redness

Ear symptoms

- | NOW | PAST | NOW | PAST |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Discharge from ears
- Pain in ears
- Chronic ear infections
- Ringing/noises in ears
- Hearing loss
- Itching in ears

Nose symptoms

- | NOW | PAST | NOW | PAST |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- Nose bleeds
- Loss of smell
- Congestion
- Sinus infections
- Breathing problems: day night
- Frequent sneezing
- Eruptions/sores

Facial symptoms

NOW	PAST	NOW	PAST
-----	------	-----	------

- | | | | | | |
|--------------------------|--------------------------|----------------|--------------------------|------------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pain/neuralgia | <input type="checkbox"/> | Excessive sweating | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Acne | <input type="checkbox"/> | Discoloration (which color?) | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Twitching | | | |

Mouth/Teeth symptoms

NOW	PAST	NOW	PAST
-----	------	-----	------

- | | | | | | |
|--------------------------|--------------------------|----------------------|--------------------------|---|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Gum infections | <input type="checkbox"/> | TMJ pain (temporomandibular joint) | |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding gums | <input type="checkbox"/> | Cracked lips | |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever blisters | <input type="checkbox"/> | Cracking in jaw | |
| <input type="checkbox"/> | <input type="checkbox"/> | Bad breath | <input type="checkbox"/> | Peculiar taste (please describe): | |
| <input type="checkbox"/> | <input type="checkbox"/> | Canker sores/aphthae | <input type="checkbox"/> | Cracks on tongue | |
| <input type="checkbox"/> | <input type="checkbox"/> | Many dental cavities | <input type="checkbox"/> | Loss of teeth | |
| <input type="checkbox"/> | <input type="checkbox"/> | Tooth sensitivity | <input type="checkbox"/> | Excessive salivation: <input type="checkbox"/> day <input type="checkbox"/> night | |

Digestive symptoms

NOW	PAST	NOW	PAST
-----	------	-----	------

- | | | | | | |
|--------------------------|--------------------------|---------------------------|--------------------------|---------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Heartburn | <input type="checkbox"/> | Bloating | |
| <input type="checkbox"/> | <input type="checkbox"/> | Indigestion | <input type="checkbox"/> | Belching | |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent nausea | <input type="checkbox"/> | Flatulence/passing gas | |
| <input type="checkbox"/> | <input type="checkbox"/> | Recurrent vomiting | <input type="checkbox"/> | Marked thirst | |
| <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | Thirstless | |
| <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | Appetite increased | |
| <input type="checkbox"/> | <input type="checkbox"/> | Bloody stools | <input type="checkbox"/> | Appetite decreased | |
| <input type="checkbox"/> | <input type="checkbox"/> | Light colored stools | <input type="checkbox"/> | Hurried eating | |
| <input type="checkbox"/> | <input type="checkbox"/> | Rectal pain | <input type="checkbox"/> | Loss of taste | |
| <input type="checkbox"/> | <input type="checkbox"/> | Rectal itching | <input type="checkbox"/> | Difficulty swallowing | |
| <input type="checkbox"/> | <input type="checkbox"/> | Worse from missing a meal | <input type="checkbox"/> | Abdominal or stomach pain | |

Do you have a strong desire for any particular foods?

Do you strongly dislike any particular foods?

Are there any foods which make you feel bad or aggravate any of your symptoms?

Urogenital symptoms

NOW	PAST	NOW	PAST
-----	------	-----	------

- | | | | | | |
|--------------------------|--------------------------|-----------------------|--------------------------|---|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination | <input type="checkbox"/> | Strong smelling urine | |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful urination | <input type="checkbox"/> | Blood in urine | |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficult urination | <input type="checkbox"/> | Frequent masturbation | |
| <input type="checkbox"/> | <input type="checkbox"/> | Involuntary urination | <input type="checkbox"/> | Change in sexual energy (please specify): | |

Male symptoms

NOW	PAST	NOW	PAST
<input type="checkbox"/>	<input type="checkbox"/>	Difficult or loss of erection	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Painful erections	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Discharges	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Lumps or swelling in testicles	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>

Female symptoms

NOW	PAST	NOW	PAST
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal infections/discharge	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal itching	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cervical problems	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding between menstrual periods	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Painful intercourse	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	PMS (premenstrual syndrome)	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Excessive menstrual flow	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Vaginal dryness	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Few or no orgasms	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pain in breasts	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Swelling or lumps in breasts	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Discharge from breasts	<input type="checkbox"/>

When did you begin menstruating?

How long do your periods usually last?

Number of pregnancies: Number of births: Cesareans: Miscarriages: Abortions:

Any complications during pregnancy? yes no If so, what?

Did you breastfeed your children? yes no If so, how long?

Respiratory Symptoms

NOW	PAST	NOW	PAST
<input type="checkbox"/>	<input type="checkbox"/>	Persistent/recurrent hoarseness	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Loss of voice	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Persistent throat pain	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chronic throat infections	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Swollen tonsils	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Frequent chest colds	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Coughing up mucus	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pain on breathing	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing when walking	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing when climbing stairs	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing when lying	<input type="checkbox"/>

Cardiovascular symptoms

NOW	PAST	NOW	PAST
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain at rest	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain with walking/exertion	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Ankle or leg swelling	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Leg pain unrelated to injury	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising or bleeding (from where?):	<input type="checkbox"/>

Skin symptoms

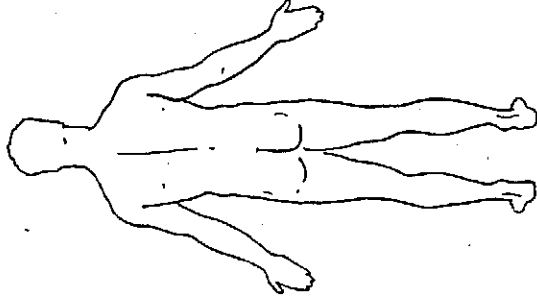
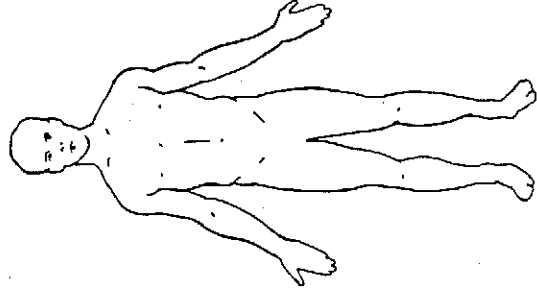
NOW	PAST	NOW	PAST
<input type="checkbox"/>	<input type="checkbox"/>	Rough skin, dry skin	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Moles	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Nail changes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Shingles/herpes	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pimples	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>

Skin symptoms (continued)

NOW	PAST	NOW	PAST
<input type="checkbox"/>	<input type="checkbox"/>	Warts	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Cysts	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Infections	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Hives or urticaria	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands (location?):	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Eczema (location?):	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Pustules	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Discoloration (what color?)	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Skin cracks (location?)	<input type="checkbox"/>

Musculoskeletal symptoms

NOW	PAST	LOCATION
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Swelling
<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	Tightness
<input type="checkbox"/>	<input type="checkbox"/>	Burning/heat
<input type="checkbox"/>	<input type="checkbox"/>	Coldness
<input type="checkbox"/>	<input type="checkbox"/>	Twitching
<input type="checkbox"/>	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis



On the pictures, shade in or draw arrows indicating the areas that are troubling you and write **PAIN**, **ITCHING**, **SWELLING**, etc. to identify the musculoskeletal or skin symptoms you are experiencing.

Please list any symptoms not covered in the sections above, or add any information to help clarify your history
