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Name_____ Date_____

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

_____ Trouble seeing
_____ Blind spots
_____ Double vision
_____ Blurred vision
_____ Eye pain
_____ Wear contacts/glasses

_____ Hearing loss
_____ Ringing in the ears
_____ Frequent colds
_____ Nosebleeds
_____ Tooth or gum disease
_____ Sore tongue
_____ Sore throats
_____ Tonsillitis
_____ Difficulty swallowing
_____ Hoarseness
_____ Voice change
_____ History of thyroid disease

_____ Shortness of breath
_____ Cough up phlegm/sputum
_____ Coughing up blood

_____ Chest pain
_____ Palpitations
_____ Irregular heartbeat
_____ Previous heart attack
_____ Heart Failure
_____ Swelling of ankles

_____ Loss of appetite
_____ Belching
_____ Nausea
_____ Vomiting
_____ Abdominal pain
_____ Food intolerances
_____ Jaundice/Gallstones
_____ Diarrhea
_____ Constipation
_____ Hemorrhoids
_____ Hernia
_____ Vomiting blood
_____ Ulcers
_____ Reflux
_____ Blood in stools
_____ Change in bowel habits
_____ Use Laxatives regularly
_____ 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

_____ Dizziness/Vertigo
_____ Light-headedness
_____ Seizures
_____ Abnormal movements
_____ Stroke
_____ Weakness/Tremors
_____ Insomnia
_____ Memory loss
_____ Paralysis
_____ Numbness

_____ Frequent urination
_____ Painful urination
_____ Urinary infections
_____ Incontinence
_____ Blood in urine
_____ Urgency
_____ Protein in urine
_____ Kidney stones
_____ Trouble starting stream
_____ Urinating at night

_____ Age at first period
_____ Interval between periods
_____ Menopausal (age?___)
_____ Endometriosis
_____ Severe cramps
_____ PMS
_____ Onset of last period (date:_____)

_____ Cancer: Site:_____
_____ Treatment_____
_____ Date completed_____

_____ Arthritis
_____ Joint pain, swelling
_____ Bone disease
_____ Back trouble

_____ Thyroid disease
_____ Hair/nail changes
_____ Heat/cold intolerance
_____ Depression
_____ Fibromyalgia
_____ Emotional difficulties
_____ Change in skin pigment
_____ Skin trouble
_____ H1V disease
_____ Other STD

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?_____