Name___________________________________ Date___________________

Please mark the appropriate squares in the following list of symptoms.
If you have had a symptom in the past and do not have it now, check the square like this: ☑
If the symptoms are ongoing, re-occurring or you are having the symptom at the present time, fill in the square like this: ■

HEAD & NECK
- ☐ Dizziness
- ☐ Fainting
- ☐ Neck Stiffness
- ☐ Enlarged lymph glands
- ☐ Headaches
- ☐ Other _______________

EARS
- ☐ Infection
- ☐ Pain
- ☐ Ringing
- ☐ Decreased hearing
- ☐ Congestion
- ☐ Other ________________

EYES
- ☐ Blurred vision
- ☐ Visual changes
- ☐ Spots
- ☐ Eye inflammation
- ☐ Other _________________

NOSE, THROAT & MOUTH
- ☐ Bleeding
- ☐ Sinus infection
- ☐ Hay fever or allergies
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Changes in taste
- ☐ Changes in smell
- ☐ Oral ulcers
- ☐ Other _________________

SKIN
- ☐ Hives
- ☐ Rashes
- ☐ Eczema
- ☐ Itching
- ☐ Night sweating
- ☐ Excess sweating
- ☐ Dryness
- ☐ Bruise easily
- ☐ Changes in moles or lumps
- ☐ Other _________________

RESPIRATORY
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Coughing up phlegm
- ☐ Difficulty breathing
- ☐ Wheezing/asthma
- ☐ Frequent Colds
- ☐ Other _________________

CARDIO-VASCULAR
- ☐ Palpitations
- ☐ Chest pain or tightness
- ☐ Rapid heart beat
- ☐ Irregular heart beat
- ☐ Poor circulation
- ☐ Swelling of ankles
- ☐ Phlebitis
- ☐ Other ___________________

GASTROINTESTINAL
- ☐ Indigestion
- ☐ Bloating
- ☐ Stomach Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Poor appetite
- ☐ Excessive hunger
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Blood in stool or black stools
- ☐ Hemorrhoids
- ☐ Gall bladder disorder
- ☐ Recent change in weight
- ☐ Food cravings
- ☐ Other ___________________

NEUROLOGICAL
- ☐ Seizures
- ☐ Tremors
- ☐ Numbness or tingling of limbs
- ☐ Pain
- ☐ Paralysis
- ☐ Other ___________________

MUSCLE & JOINT
- ☐ Joint disorder
- ☐ Sore or painful muscles
- ☐ Weak muscles
- ☐ Difficulty walking
- ☐ Spinal curvature
- ☐ Backache or pain
- ☐ Other ___________________

UROGENITAL
- ☐ Pain/ itching of genitalia
- ☐ Genital lesions/ discharge
- ☐ Painful urination
- ☐ Frequent urination
- ☐ Excessive or scanty urination
- ☐ Blood in urine
- ☐ Diminished bladder control
- ☐ Other ___________________

FEMALE
- ☐ Frequent urinary tract infections
- ☐ Frequent vaginal infection
- ☐ Pelvic inflammatory disease
- ☐ Abnormal Pap smear
- ☐ Uterine fibroids
- ☐ Irregular periods
- ☐ Painful menstrual periods
- ☐ Abnormal bleeding
- ☐ Menopausal symptoms
- ☐ Premenstrual symptoms
- ☐ Breast Pain
- ☐ Breast Lumps
- ☐ Nipple discharge
- ☐ Other __________________

Date of last menstrual period:
____

Date of last Pap smear:
____

Were Pap results normal?
☐ Yes ☐ No

Date of Last mammogram:
____

Are you pregnant?__________

Are you nursing? ___________

Do you use birth control?
☐ Yes ☐ No Type:_________

MALE
- ☐ Lumps in testicles
- ☐ Prostate problem
- ☐ Weak urinary stream
- ☐ Impotence
- ☐ Other ____________________

GENERAL
- ☐ Insomnia
- ☐ Vivid dreams / nightmares
- ☐ Anxiety
- ☐ Irritability
- ☐ Forgetfulness
- ☐ Depression
- ☐ Fatigue
- ☐ Feel hot or cold
- ☐ Aversion to heat or cold
- ☐ Fever and/or chills
- ☐ Thirst
- ☐ Psychiatric treatment
- ☐ Other ____________________

Do you exercise? ☐ Yes ☐ No
If so, what and how often?
____