

Patient Name: _____ Birthdate: _____

PLEASE ANSWER ALL QUESTIONS COMPLETELY-DO NOT LEAVE ANY BLANKS. Is the patient currently having problems with any of the following? Circle the appropriate response.

Constitutional:

- | | | | |
|-----------------------------|-----|----|-----|
| 1. Weight gain | yes | no | N/A |
| 2. Weight loss | yes | no | N/A |
| 3. Poor energy/ fatigue | yes | no | N/A |
| 4. Increased energy level | yes | no | N/A |
| 5. Insomnia/ sleep problems | yes | no | N/A |
| 6. Fever | yes | no | N/A |
| 7. Weakness | yes | no | N/A |

Hematologic:

- | | | | |
|-----------|-----|----|-----|
| 1. Anemia | yes | no | N/A |
|-----------|-----|----|-----|

Allergic:

- | | | | |
|--------------|-----|----|-----|
| 1. Allergies | yes | no | N/A |
|--------------|-----|----|-----|
- If yes-- to what?

Breasts:

- | | | | |
|----------------------------------|-----|----|-----|
| 1. Nipple discharge | yes | no | N/A |
| 2. Performs monthly breast exams | yes | no | N/A |

Heart:

- | | | | |
|---------------------------------|-----|----|-----|
| 1. High blood pressure | yes | no | N/A |
| 2. Chest pain/tightness | yes | no | N/A |
| 3. Rapid/racing heart rate | yes | no | N/A |
| 4. Palpitations(skipping beats) | yes | no | N/A |

Urinary:

- | | | | |
|-------------------------------|-----|----|-----|
| 1. Frequent urination | yes | no | N/A |
| 2. Excess urination | yes | no | N/A |
| 3. Urinating during the night | yes | no | N/A |

Eyes:

- | | | | |
|---------------------------------|-----|----|-----|
| 1. Blurry vision | yes | no | N/A |
| 2. Double vision | yes | no | N/A |
| 3. Change in appearance of eyes | yes | no | N/A |

Ears:

- | | | | |
|---------------------|-----|----|-----|
| 1. Hearing problems | yes | no | N/A |
|---------------------|-----|----|-----|

Nose:

- | | | | |
|-----------------------------|-----|----|-----|
| 1. Decreased sense of smell | yes | no | N/A |
| 2. Loss of sense of smell | yes | no | N/A |

Mouth/Throat:

- | | | | |
|---------------|-----|----|-----|
| 1. Hoarseness | yes | no | N/A |
|---------------|-----|----|-----|

Neck:

- | | | | |
|-----------------------------|-----|----|-----|
| 1. Lumps | yes | no | N/A |
| 2. Swollen glands | yes | no | N/A |
| 3. Pain in neck | yes | no | N/A |
| 4. Stiffness in neck | yes | no | N/A |
| 5. Goiter(enlarged thyroid) | yes | no | N/A |

Respiratory:

- | | | | |
|-------------|-----|----|-----|
| 1. Wheezing | yes | no | N/A |
| 2. Asthma | yes | no | N/A |

Musculoskeletal:

- | | | | |
|----------------------|-----|----|-----|
| 1. Muscle aches/pain | yes | no | N/A |
| 2. Joint aches/pain | yes | no | N/A |
| 3. Muscle weakness | yes | no | N/A |

Skin & Hair:

- | | | | |
|-----------------------|-----|----|-----|
| 1. Dry skin | yes | no | N/A |
| 2. Oily skin | yes | no | N/A |
| 3. Acne | yes | no | N/A |
| 4. Oily hair | yes | no | N/A |
| 5. Hair loss | yes | no | N/A |
| 6. Excess hair growth | yes | no | N/A |

