Your Personalized Health History & Wellness Comprehensive Questionnaire

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PERSONAL INFORMATION

Name	*First*	*Middle*	*Last*	
Preferred Name				
Date of Birth			*Age*	
Gender	☐Male	☐Female		
Genetic Background	☐African	☐European	☐Native American	☐Mediterranean
	☐Asian	☐Ashkenazi	☐Middle Eastern	☐
Highest Education Level	☐High School	☐Under-Graduate	☐Post-Graduate	
Business or Profession				
Your Position				
Your Primary Address	*Number, Street*			
	City		*State*	*Zip*
Alternate Address	*Number, Street*			
	City		*State*	*Zip*
Home Phone			Work Phone	
Cell Phone			Fax	
E-mail				
Emergency Contact	*Name*		*Phone Number*	
Relationship				
Primary Care Physician	*Name*		*Phone Number*	
	Fax			
Referred by	☐Book	☐Website	☐Media	☐Family or Friend
	☐Primary Care	☐ Specialist	☐Other Providers	

ALLERGIES

Medication / Supplement / Food	Reaction

COMPLAINTS AND HEALTH CONCERNS

What do you want to achieve in your visit? _____

What is your main complaint? _____

What are your three most challenging health concerns?

1. _____
2. _____
3. _____

When did you last feel well? _____

What triggered your condition? Accident? Infection? Stress? _____

_____

What makes you feel worse? _____

_____

What makes you feel better? _____

_____

List other chronic problems in order of severity or concern:

Problem	Mild	Moderate	Severe	Prior Treatment & Results	Excellent	Good	Fair

MEDICAL HISTORY

Check appropriate box and provide date of onset:

Past Condition	*Ongoing Condition*	
		GASTROINTESTINAL
☐	☐	Irritable Bowel Syndrome_____
☐	☐	Inflammatory Bowel Disease_____
☐	☐	Crohn's_____
☐	☐	Ulcerative Colitis_____
☐	☐	Gastritis or Peptic Ulcer Disease_____
☐	☐	GERD (reflux)_____
☐	☐	Celiac Disease_____
☐	☐	Other _____
		CARDIOVASCULAR
☐	☐	Heart Attack_____
☐	☐	Other Heart Disease_____
☐	☐	Stroke_____
☐	☐	Elevated Cholesterol_____
☐	☐	Arrhythmia (irregular heart rate)_____
☐	☐	Hypertension (high blood pressure)_____
☐	☐	Rheumatic Fever_____
☐	☐	Mitral Valve Prolapse_____
☐	☐	Other _____
		METABOLIC/ENDOCRINE
☐	☐	Type 1 Diabetes_____
☐	☐	Type 2 Diabetes_____
☐	☐	Hypoglycemia_____
☐	☐	Metabolic Syndrome_____ (Insulin Resistance or Pre-Diabetes)
☐	☐	Hypothyroidism (low thyroid)_____
☐	☐	Hyperthyroidism (overactive thyroid)_____
☐	☐	Endocrine Problems_____
☐	☐	Polycystic Ovarian Syndrome (PCOS)_____
☐	☐	Infertility_____
☐	☐	Weight Gain_____
☐	☐	Weight Loss_____
☐	☐	Frequent Weight Fluctuations_____
☐	☐	Bulimia_____
☐	☐	Anorexia_____
☐	☐	Binge Eating Disorder_____
☐	☐	Night Eating Syndrome_____
☐	☐	Eating Disorder (non-specific)_____
☐	☐	Other _____
		CANCER
☐	☐	Lung Cancer_____
☐	☐	Breast Cancer_____
☐	☐	Colon Cancer_____
☐	☐	Ovarian Cancer_____
☐	☐	Prostate Cancer_____
☐	☐	Skin Cancer_____
☐	☐	Other _____

Past Condition	*Ongoing Condition*	
		GENITAL AND URINARY SYSTEM
☐	☐	Kidney Stones_____
☐	☐	Gout_____
☐	☐	Interstitial Cystitis_____
☐	☐	Frequent Urinary Tract Infections_____
☐	☐	Frequent Yeast Infections_____
☐	☐	Erectile Dysfunction_____
☐	☐	Other_____
		MUSCULOSKELETAL/PAIN
☐	☐	Osteoarthritis_____
☐	☐	Fibromyalgia_____
☐	☐	Chronic Pain_____
☐	☐	Other _____
		INFLAMMATORY/AUTOIMMUNE
☐	☐	Chronic Fatigue Syndrome_____
☐	☐	Autoimmune Disease_____
☐	☐	Rheumatoid Arthritis_____
☐	☐	Lupus SLE_____
☐	☐	Immune Deficiency Disease_____
☐	☐	Herpes-Genital_____
☐	☐	Severe Infectious Disease_____
☐	☐	Poor Immune Function_____ (frequent infections)
☐	☐	Food Allergies_____
☐	☐	Environmental Allergies_____
☐	☐	Multiple Chemical Sensitivities_____
☐	☐	Latex Allergy_____
☐	☐	Other _____
		RESPIRATORY DISEASES
☐	☐	Asthma_____
☐	☐	Chronic Sinusitis_____
☐	☐	Bronchitis_____
☐	☐	Emphysema_____
☐	☐	Pneumonia_____
☐	☐	Tuberculosis_____
☐	☐	Sleep Apnea_____
☐	☐	Other _____
		SKIN DISEASES
☐	☐	Eczema_____
☐	☐	Psoriasis_____
☐	☐	Acne_____
☐	☐	Melanoma_____
☐	☐	Skin Cancer_____
☐	☐	Other _____

YOUR MEDICAL HISTORY (CONTINUED)

NEUROLOGICAL

Past Condition	*Ongoing Condition*	
☐	☐	Depression_____
☐	☐	Anxiety_____
☐	☐	Bipolar Disorder_____
☐	☐	Schizophrenia_____
☐	☐	Headaches_____
☐	☐	Migraines_____
☐	☐	ADD/ADHD_____
☐	☐	Autism_____
☐	☐	Mild Cognitive Impairment_____
☐	☐	Memory Problems_____
☐	☐	Parkinson's Disease_____
☐	☐	Multiple Sclerosis_____
☐	☐	ALS_____
☐	☐	Seizures_____
☐	☐	Other Neurological Problems_____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam_____
- ☐ Bone Density_____
- ☐ Colonoscopy_____
- ☐ Cardiac Stress Test_____
- ☐ EBT Heart Scan_____
- ☐ EKG_____
- ☐ Hemoccult Test-stool test for blood_____
- ☐ MRI_____
- ☐ CT Scan_____
- ☐ Upper Endoscopy_____
- ☐ Upper GI Series_____
- ☐ Ultrasound_____

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy_____
- ☐ Hysterectomy +/- Ovaries_____
- ☐ Gall Bladder_____
- ☐ Hernia_____
- ☐ Tonsillectomy_____
- ☐ Dental Surgery_____
- ☐ Joint Replacement – Knee/Hip_____
- ☐ Heart Surgery - Bypass Valve_____
- ☐ Angioplasty or Stent_____
- ☐ Pacemaker_____
- ☐ Other_____
- ☐ None

INJURIES

- ☐ Back Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Broken Bones
- ☐ Other_____

BLOOD TYPE:

- ☐ A
- ☐ B
- ☐ AB
- ☐ O
- ☐ Rh+
- ☐ Unknown

HOSPITALIZATION ☐ None

Date	*Reason*

COMMENTS OR ADDITIONS

GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY *Check box and if answered yes and the provide number of each.*

☐ Pregnancies_____ ☐ Caesarean_____ ☐ Vaginal Deliveries_____

☐ Miscarriage_____ ☐ Abortion_____ ☐ Living Children_____

☐ Post-Partum Depression ☐Toxemia ☐Gestational Diabetes ☐Baby Over 8 Pounds

☐ Breast feeding for how long?_____

MENSTRUAL HISTORY

Age at first period:_____Menstrual frequency:_____Length:_____Pain: ☐Yes ☐No Clotting: ☐Yes

☐No Have you skipped periods?_____For how long?_____

_____

Date of your last period:_____

Do you use hormonal contraception? ☐ Birth Control Pills ☐Patch ☐Nuva Ring How long?_____

Do you use contraception? ☐Yes ☐No ☐Condom ☐Diaphragm ☐IUD ☐Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐Endometriosis ☐Fibroids ☐Infertility

☐ Painful Periods ☐Heavy Periods ☐PMS ☐PCOS – Polycystic Ovarian Syndrome

Last Mammogram:_____☐Breast Biopsy/Date:_____☐Breast Ultrasound ☐MRI

Last PAP Test:_____☐Normal ☐Abnormal

Last Bone Density:_____Results: ☐Osteopenia ☐Osteoporosis ☐Within Normal Range

Are you post-menopausal? ☐Yes ☐No

How old were you at menopause? _____

☐Hot Flashes ☐Mood Swings ☐Concentration/Memory Problems ☐Vaginal Dryness ☐Decreased Libido

☐Heavy Bleeding ☐Joint Pains ☐Headaches ☐Weight Gain ☐ Urinary Incontinence ☐Palpitations

☐Do you use hormone replacement therapy? ☐Yes ☐No For how long?___

What hormones do you use? _____

MALE HEALTH HISTORY (for men only)

Has your PSA level been checked recently? ☐Yes ☐No

PSA Level: ☐0-2 ☐2-4 ☐4-10 ☐> 10

☐ Prostate Enlargement ☐Prostate Infection ☐Change in Libido ☐Impotence

☐ Difficulty Obtaining an Erection ☐Difficulty Maintaining an Erection

☐ Nocturia (urination at night). How many times at night?_____

☐ Urgency/Hesitancy/Change in Urinary Stream ☐Loss of Control of Urine

Check the questions below that pertain to you:

_ Have you been diagnosed with osteoporosis?

_ Do you have chronically dry skin?

_ Are you losing body hair, especially on your legs?

_ Are you balding?

_ Do you experience unexplainable unhappiness?

_ Have you become more irritable?

_ Do you have less ability to cope with stress?

_ Are you more emotional?

_ Does your body temperature fluctuate easily?

_ Do experience hot flushes?

_ Do you have chronic pain?

_ Have you experienced gradual weight gain?

_ Do you find it hard to lose weight?

_ Are you retaining fat in your abdomen (increased belly fat)?

_ Do you produce less semen so your ejaculation quantity is reduced?

_ Have you been diagnosed with insulin resistance, diabetes, or metabolic syndrome?

_ Do you have low growth hormone levels or low IGF-1?

_ Do you have high red blood cell count or high hemoglobin?

_ Do you have a cardiovascular condition, like irregular heart rate, high blood pressure, or high LDL cholesterol?

_ Do you have high iron levels?

_ Have you been diagnosed with any type of cancer?

GASTROINTESTINAL HISTORY

Foreign Travel ☐Yes ☐No Where?_____

Wilderness Camping ☐Yes ☐No Where?_____

Have you ever had severe: ☐ Gastroenteritis ☐Diarrhea

Do you feel like you digest your food well? ☐Yes ☐No

Do you feel bloated after meals? ☐Yes ☐No

Have you had microbiome testing? ☐Yes ☐No

Do you have IBS? ☐Yes ☐No

Gluten sensitivity? ☐Yes ☐No

Celiac Disease? ☐Yes ☐No

Colitis? ☐Yes ☐No

Crohn's Disease ☐Yes ☐No

VACCINATION HISTORY

List all vaccinations that you can recall having including childhood vaccines, military, and for travel:

Any reactions to vaccines? ☐Yes ☐No

If Yes, what were they?

BIRTH HISTORY

☐ Term ☐Premature

Pregnancy Complications:_____

Birth Complications:_____

☐ Breast Fed How long?_____ ☐Bottle Fed

Age at introduction of: Solid Foods:_____ Dairy:_____ Wheat:_____

DENTAL HISTORY

☐ Silver Mercury Fillings How many?_____

☐ Gold Fillings ☐Root Canals ☐Implants ☐Tooth Pain ☐Bleeding Gums

☐ Gingivitis ☐Problems with

Chewing Do you floss regularly?

☐Yes ☐No

Have you had DNA bacteria testing? ☐Yes ☐No

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS (*Last 10 years)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? ☐Yes ☐No

Describe:_____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐Yes ☐No

Have you had prolonged use of Tylenol? ☐Yes ☐No

Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.) ☐Yes ☐No

Frequent antibiotics ☐Yes ☐No

Long term antibiotics ☐Yes ☐No

Use of steroids (prednisone, nasal allergy inhalers) in the past ☐Yes ☐No

Use of oral contraceptives ☐Yes ☐No

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson’s												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? ☐Yes ☐No

Have you made any changes in your eating habits because of your health? ☐Yes ☐No Describe:_____

Do you currently follow a special diet or nutritional program? ☐Yes ☐No

Check all that apply:

☐ Low Fat ☐Low Carbohydrate ☐High Protein ☐Low Sodium ☐Diabetic ☐No Dairy ☐No Wheat

☐ Gluten Restricted ☐Vegetarian ☐Vegan ☐Ultrametabolism

☐ Specific Program for Weight Loss/Maintenance Type:_____ ☐Other_____

Height (feet/inches)_____	Current Weight_____
Usual Weight Range +/- 5 lbs_____	Desired Weight Range +/- 5 lbs_____
Highest Adult Weight_____	Lowest Adult Weight_____
Weight Fluctuations (>10 lbs) ☐Yes ☐No	Body Fat %_____

How often do you weigh yourself? ☐Daily ☐Weekly ☐Monthly ☐Rarely ☐Never

Have you ever had your metabolism (resting metabolic rate) checked? ☐Yes ☐ No If yes, what was it?_____

Do you avoid any particular foods? ☐Yes ☐ No If yes, types and reason_____

_____

If you could only eat a few foods a week, what would they be?_____

_____

Do you grocery shop? ☐Yes ☐ No If no, who does the shopping?_____

Do you read food labels? ☐Yes ☐No

Do you cook? ☐Yes ☐No If no, who does the cooking?_____

How many meals to you eat out per week? ☐0-1 ☐1-3 ☐3-5 ☐> 5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% meals away from home
☐ Travel frequently
☐ Non-availability of healthy foods
☐ Do not plan meals or menus
☐ Reliance on convenience items
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods
☐ Significant other or family members have special dietary needs or food preferences
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, depressed, bored)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is:_____

SMOKING

Currently Smoking? ☐Yes ☐ No, If yes, how many years?_____ Packs per day:_____

Attempts to quit:_____

Previous Smoking: How many years?_____ Packs per day:_____

Second Hand Smoke Exposure?_____

ALCOHOL INTAKE

How many drinks currently per week? *1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits*

☐ None ☐1-3 ☐4-6 ☐7-10 ☐ > 10 *If none, skip to "Other Substances"*

Previous alcohol intake? ☐ Yes (☐ Mild ☐ Moderate ☐High) ☐ None

Have you ever been told you should cut down your alcohol intake? ☐Yes ☐No

Do you get annoyed when people ask you about your drinking? ☐Yes ☐No

Do you ever feel guilty about your alcohol consumption? ☐Yes ☐No

Do you have a high tolerance to alcohol? ☐Yes ☐No

Have you ever been unable to remember what you did during a drinking episode? ☐Yes ☐No

Do you get into arguments or physical fights when you have been drinking? ☐Yes ☐No

Have you ever thought about getting help to control or stop your drinking? ☐Yes ☐No

OTHER SUBSTANCES

Caffeine Intake: ☐Yes ☐ No | Coffee cups/day: ☐ 1 ☐ 2-4 ☐ > 4 | Tea cups/day: ☐ 1 ☐ 2-4 ☐ > 4

Caffeinated Sodas or Diet Sodas Intake: ☐Yes ☐No

12-ounce can/bottle: ☐ 1 ☐ 2-4 ☐ > 4

List favorite type (Ex. Diet Coke, Pepsi, etc.): _____

Are you currently using any recreational drugs? ☐Yes ☐No If yes, type:_____

Have you ever used IV or inhaled recreational drugs? ☐Yes ☐No

EXERCISE

Current Exercise Program: (*List type of activity, number of sessions/week, and duration)*

Activity	**Type**	**Frequency Per Week**	**Duration in Minutes**
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐High

List problems that limit activity:_____

_____

Do you feel unusually fatigued after exercise? ☐Yes ☐No

If yes, please describe:_____

_____

Do you excessively sweat when exercising? ☐Yes ☐No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ☐Yes ☐No

Are you happy? ☐Yes ☐No

Do you feel your life has meaning and purpose? ☐Yes ☐No

Do you believe stress is presently reducing the quality of your life? ☐Yes ☐No

Do you like the work you do? ☐Yes ☐No

Have you ever experienced major losses in your life? ☐Yes ☐No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐Yes ☐No

Would you describe your experience as a child in your family as happy and secure? ☐Yes ☐No

STRESS/COPING

Have you ever sought counseling? ☐Yes ☐No

Are you currently in therapy? ☐Yes ☐No Describe:_____

Do you feel you have an excessive amount of stress in your life? ☐Yes ☐No

Do you feel you can easily handle the stress in your life? ☐Yes ☐No

Daily Stressors: Rate on scale of 1-10

Work_____ Family_____ Social_____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation techniques? ☐Yes ☐No How often?_____

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐Other:_____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐Yes ☐No

SLEEP/REST

Average number of hours you sleep per night: ☐ > 10 ☐ 8-10 ☐ 6-8 ☐< 6 Do

you have trouble falling asleep? ☐Yes ☐No

Do you feel rested upon awakening? ☐Yes ☐No

Do you have problems with insomnia? ☐Yes ☐No

Do you snore? ☐Yes ☐No

Do you use sleeping aids? ☐Yes ☐ No Explain:_____

ROLES/RELATIONSHIP

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Long term partnership ☐ Widow

List Children: Child's Full Name	Age	Gender

Who is Living in Household? Number:_____Names:_____

Their Employement/Occupations:_____

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐Other:_____

Are you satisfied with your sex life? ☐Yes ☐No

How well have things been going for you?	Very Well	Fine	Poorly	N/A
- Overall				
- At school				
- In your job				
- In your social life				
- With close friends				
- With sex				
- With your attitude				
- With your boyfriend/girlfriend				
- With your children				
- With your parents				
- With your spouse				

FOOD & CHEMICAL SENSITITIES

Do you have known adverse food reactions or sensitivities? ☐Yes ☐ No If yes, describe symptoms:

_____

Do you have any food allergies or sensitivities? ☐Yes List all:_____ ☐ No

Do you have an adverse reaction to caffeine? ☐Yes ☐No

When you drink caffeine do you feel: ☐ Irritable or Wired ☐Aches and Pains Do

you adversely react to *(Check all that apply)*

☐ Monosodium glutamate (MSG) ☐ Aspartame (NutraSweet) ☐ Caffeine ☐ Bananas ☐ Garlic ☐ Onion

☐ Cheese ☐ Citrus Foods ☐ Chocolate ☐ Alcohol ☐ Red Wine

☐ Sulfite Containing Foods (wine, dried fruit, salad bars) ☐ Preservatives (ex. Sodium Benzoate)

☐ Other:_____

Which of these significantly affect you? *(Check all that apply)*

☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐Other:_____

In your work or home environment, are you exposed to: ☐ Chemicals ☐ Electromagnetic Radiation ☐Mold

Have you ever turned yellow (jaundiced)? ☐Yes ☐No

Have you ever been told you have Gilbert's Syndrome or a liver disorder? ☐Yes ☐No

Explain:_____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

☐ Herbicides ☐ Insecticides (frequent visits of exterminator) ☐ Pesticides ☐ Organic Solvents

☐ Heavy Metals ☐Other_____

Chemical Name, Date, Length of Exposure:_____

Do you dry clean your clothes frequently? ☐Yes ☐No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? ☐Yes ☐No

Do you have pets or farm animals? ☐Yes ☐No

COMPREHENSIVE SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months

GENERAL

- ☐ Cold Hands & Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Low Blood Pressure
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Waking
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

HEAD, EYES & EARS

- ☐ Conjunctivitis
- ☐ Distorted Sense of Smell
- ☐ Distorted Taste
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Headache
- ☐ Migraine
- ☐ Sensitivity to Loud Noises
- ☐ Vision Problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

MUSCULOSKELETAL

- ☐ Back Muscle Spasm
- ☐ Calf Cramps
- ☐ Chest Tightness
- ☐ Foot Cramps
- ☐ Joint Deformity
- ☐ Joint Pain
- ☐ Joint Redness
- ☐ Joint Stiffness
- ☐ Muscle Pain
- ☐ Muscle Spasms
- ☐ Muscle Stiffness
- ☐ Muscle Twitches – around eyes
- ☐ Muscle Twitches – Arms or Legs
- ☐ Muscle Weakness
- ☐ Tendonitis
- ☐ Tension Headache
- ☐ TMJ Problems

MOOD/NERVES

- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression
- Difficulty
  - ☐ Concentrating
  - ☐ With Balance
  - ☐ With Thinking
  - ☐ With Judgment
  - ☐ With Speech
  - ☐ With Memory
- ☐ Dizziness (Spinning)
- ☐ Fainting
- ☐ Fearfulness
- ☐ Irritability
- ☐ Light-headedness
- ☐ Numbness
- ☐ Other Phobias
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Seizures
- ☐ Suicidal Thoughts
- ☐ Tingling
- ☐ Tremor/Trembling
- ☐ Visual Hallucinations

EATING

- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (breads, pasta)
- ☐ Sweet Cravings (candy, cookies, cakes)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

DIGESTION

- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Bloating of Lower Abdomen
- ☐ Bloating of Whole Abdomen
- ☐ Bloating After Meals
- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Cramps
- ☐ Dentures w/ Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Food "Repeat" (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting
- Intolerance to:
  - ☐ Lactose
  - ☐ All Dairy Products
  - ☐ Wheat
  - ☐ Gluten (Wheat, Rye, Barley)
  - ☐ Corn
  - ☐ Eggs
  - ☐ Fatty Foods
  - ☐ Yeast
- ☐ Liver Disease/Jaundice (yellow eyes/ skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Periodontal Disease
- ☐ Sore Tongue
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools

SKIN PROBLEMS

- ☐ Acne on Back
- ☐ Acne on Chest
- ☐ Acne on Face
- ☐ Acne on Shoulders
- ☐ Athlete's Foot
- ☐ Bumps on Back of Upper Arms
- ☐ Cellulite
- ☐ Dark Circles Under Eyes
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo

ITCHING SKIN

- ☐ Skin in General
- ☐ Anus
- ☐ Arms
- ☐ Ear Canals
- ☐ Eyes
- ☐ Feet
- ☐ Hands
- ☐ Legs
- ☐ Nipples
- ☐ Nose
- ☐ Penis
- ☐ Roof of Mouth
- ☐ Scalp
- ☐ Throat

SKIN, DRYNESS OF

- ☐ Eyes
- ☐ Feet
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Hair
- ☐ Hair Unmanageable?
- ☐ Hands
  - ☐ Any Cracking?
  - ☐ Any Peeling?
- ☐ Mouth/Throat
- ☐ Scalp
  - ☐ Any Dandruff?
- ☐ Skin in General

LYMPH NODES

- ☐ Enlarged/neck
- ☐ Tender/neck
- ☐ Other Enlarged/Tender
- ☐ Lymph Nodes

NAILS

- ☐ Bitten
- ☐ Brittle
- ☐ Curve Up
- ☐ Frayed
- ☐ Fungus-Fingers
- ☐ Fungus-Toes
- ☐ Pitting
- ☐ Ragged Cuticles
- ☐ Ridges
- ☐ Soft
- ☐ Thickening of fingernails
- ☐ Thickening of toenails
- ☐ White Spots/Lines

RESPIRATORY

- ☐ Bad Breath
- ☐ Bad Odor in Nose
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Hoarseness
- ☐ Sore Throat

Hay Fever

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Change of Season

- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Wheezing
- ☐ Winter Stuffiness

CARDIOVASCULAR

- ☐ Angina/chest pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

URINARY

- ☐ Bed Wetting
- ☐ Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urgency

MALE REPRODUCTIVE

- ☐ Discharge From Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Prostate or Urinary Infection
- ☐ Lumps in Testicles
- ☐ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex

Premenstrual:

- ☐ Bloating Breast Tenderness
- ☐ Carbohydrate Cravings
- ☐ Chocolate Cravings
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability

Menstrual:

- ☐ Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between