

**REVIEW OF SYMPTOMS**

Please indicate the following symptoms on the checklist as:

**Y = have this condition now****N= never had it****P= have experienced it in the past****Skin and Hair:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Rashes         | <input type="checkbox"/> Hives              | <input type="checkbox"/> Excess perspiration      |
| <input type="checkbox"/> Eczema         | <input type="checkbox"/> Lumps              | <input type="checkbox"/> Nail changes             |
| <input type="checkbox"/> Itching        | <input type="checkbox"/> Warts              | <input type="checkbox"/> Dry Hair                 |
| <input type="checkbox"/> Acne           | <input type="checkbox"/> Color change       | <input type="checkbox"/> Falling/thinning hair    |
| <input type="checkbox"/> Boils          | <input type="checkbox"/> Changes in mole(s) | <input type="checkbox"/> Varicose Veins           |
| <input type="checkbox"/> Skin Eruptions | <input type="checkbox"/> Skin cancer        | <input type="checkbox"/> Difficulty growing nails |
| <input type="checkbox"/> Scaling        | <input type="checkbox"/> Dryness            | <input type="checkbox"/> Night sweats             |

**Head:**

- |                                      |                                    |                                     |
|--------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Headache    | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraines  |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Vertigo   | <input type="checkbox"/> Pulsations |
| <input type="checkbox"/> Faintness   | <input type="checkbox"/> Insomnia  | <input type="checkbox"/> Drowsiness |

**Eyes:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Impaired vision  | <input type="checkbox"/> Double vision         | <input type="checkbox"/> Itching          |
| <input type="checkbox"/> Glasses/contacts | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Redness          |
| <input type="checkbox"/> Eye pain         | <input type="checkbox"/> Cataracts             | <input type="checkbox"/> Discharge        |
| <input type="checkbox"/> Tearing          | <input type="checkbox"/> Blurring              | <input type="checkbox"/> Blind spot       |
| <input type="checkbox"/> Dryness          | <input type="checkbox"/> Bothered by sun/light | <input type="checkbox"/> Near/Far sighted |

**Ears:**

- |   |                                     |                                  |
|---|-------------------------------------|----------------------------------|
| <input type="checkbox"/> Impaired hearing | <input type="checkbox"/> Discharge  | <input type="checkbox"/> Buzzing |
| <input type="checkbox"/> Earache          | <input type="checkbox"/> Infections | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Ringing    |                                  |

**Nose and Sinuses:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Hay fever     |
| <input type="checkbox"/> Stuffiness     | <input type="checkbox"/> Nose bleeds    | <input type="checkbox"/> Loss of smell |
| <input type="checkbox"/> Discharge      | <input type="checkbox"/> Obstruction    |  |

**Mouth and Throat:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Jaw pain/clicking jaw | <input type="checkbox"/> Gum problems  | <input type="checkbox"/> Dental cavities          |
| <input type="checkbox"/> Frequent sore throat  | <input type="checkbox"/> Hoarseness    | <input type="checkbox"/> Dry/cracked/chapped lips |
| <input type="checkbox"/> Sore tongue/mouth     | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Canker sores/Cold Sores  |

**Neck:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Lumps                | <input type="checkbox"/> Goiter            | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Swollen glands/lymph | <input type="checkbox"/> Pain or stiffness |  |

**Respiratory:**

- |  |                                     |   |
|--|-------------------------------------|---|
| <input type="checkbox"/> Cough         | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Difficulty breathing |
| <input type="checkbox"/> Sputum/mucous | <input type="checkbox"/> Pneumonia  | <input type="checkbox"/> Pain on breathing    |
| <input type="checkbox"/> Wheezing      | <input type="checkbox"/> Pleurisy   | <input type="checkbox"/> Shortness of breath  |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Other:        |                                     |   |

**Cardiovascular:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Chest pain              | <input type="checkbox"/> Heart testing             |
| <input type="checkbox"/> Angina              | <input type="checkbox"/> Swelling in ankles      | <input type="checkbox"/> Pain in chest on exertion |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Palpitations/fluttering | <input type="checkbox"/> Blue lips                 |
| <input type="checkbox"/> Murmurs             | <input type="checkbox"/> Cyanosis                |  |
| <input type="checkbox"/> Rheumatic fever     | <input type="checkbox"/> EC                      |  |
| <input type="checkbox"/> Other:              |  |  |

**Peripheral:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Deep leg pain   | <input type="checkbox"/> Thrombophlebitis | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Leg cramps      | <input type="checkbox"/> Numbness         | <input type="checkbox"/> Swelling       |
| <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Coldness         | <input type="checkbox"/> Ulcers         |
| <input type="checkbox"/> Other:          |   |   |

**Gastrointestinal:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Trouble swallowing   | <input type="checkbox"/> Regular bowel movements     | <input type="checkbox"/> Rectal bleeding     |
| <input type="checkbox"/> Heartburn            | <input type="checkbox"/> Recent changes in bowel     | <input type="checkbox"/> Hemorrhoids         |
| <input type="checkbox"/> Change in thirst     | <input type="checkbox"/> Blood in stool              | <input type="checkbox"/> Black, tarry stool  |
| <input type="checkbox"/> Change in appetite   | <input type="checkbox"/> Belching or passing gas     | <input type="checkbox"/> Abdominal pain      |
| <input type="checkbox"/> Nausea               | <input type="checkbox"/> Jaundice (yellow skin/eyes) | <input type="checkbox"/> Food allergy        |
| <input type="checkbox"/> Gall bladder disease | <input type="checkbox"/> Liver disease               | <input type="checkbox"/> Hunger after eating |
| <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Indigestion                 | <input type="checkbox"/> Hernias             |
| <input type="checkbox"/> Vomiting blood       | <input type="checkbox"/> Diarrhea                    |  |
| <input type="checkbox"/> Other:               |  |  |

**Urinary:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Pain on urination   | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Urgency           |
| <input type="checkbox"/> Increased frequency | <input type="checkbox"/> Kidney stones       | <input type="checkbox"/> Hesitancy         |
| <input type="checkbox"/> Frequency at night  | <input type="checkbox"/> Blood in urine      | <input type="checkbox"/> Inability to hold |
| <input type="checkbox"/> Other:              |  |  |

**Musculoskeletal:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Joint pain or stiffness | <input type="checkbox"/> Muscle spasms/cramps | <input type="checkbox"/> Backache         |
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Weakness             | <input type="checkbox"/> Tight muscles    |
| <input type="checkbox"/> Broken bones            | <input type="checkbox"/> Joint swelling       | <input type="checkbox"/> Muscle twitching |
| <input type="checkbox"/> Other:                  |   |   |

**Male Concerns:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Hernias           | <input type="checkbox"/> Are you sexually active? | <input type="checkbox"/> Discharge or sores |
| <input type="checkbox"/> Testicular masses | <input type="checkbox"/> Sexual difficulties      |   |
| <input type="checkbox"/> Testicular pain   | <input type="checkbox"/> Venereal disease         |   |

**Female Concerns:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Average number of days       | <input type="checkbox"/> Number of pregnancies    | <input type="checkbox"/> Vaginal discharge      |
| <input type="checkbox"/> Length of cycle              | <input type="checkbox"/> Number of live births    | <input type="checkbox"/> Vaginal itching        |
| <input type="checkbox"/> Bleeding between cycle       | <input type="checkbox"/> Number of miscarriages   | <input type="checkbox"/> Last PAP               |
| <input type="checkbox"/> Regularity of cycle          | <input type="checkbox"/> Number of abortions      | <input type="checkbox"/> Ceasing of menses      |
| <input type="checkbox"/> Painful menses               | <input type="checkbox"/> Difficulty conceiving    | <input type="checkbox"/> Hot flashes            |
| <input type="checkbox"/> Excessive flow               | <input type="checkbox"/> Are you sexually active? | <input type="checkbox"/> Breast lumps           |
| <input type="checkbox"/> Scanty flow                  | <input type="checkbox"/> Pain during intercourse  | <input type="checkbox"/> Breast pain/tenderness |
| <input type="checkbox"/> PMS symptoms                 | <input type="checkbox"/> Sexual difficulties      | <input type="checkbox"/> Nipple discharge       |
| <input type="checkbox"/> Birth control – type/length? | <input type="checkbox"/> Venereal disease         |   |
| <input type="checkbox"/> Other:                       |   |   |

**Neurologic:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Fainting             | <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Speech problems                |
| <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Loss of memory       | <input type="checkbox"/> Tremors                        |
| <input type="checkbox"/> Paralysis            | <input type="checkbox"/> Involuntary movement | <input type="checkbox"/> Difficulty concentrating       |
| <input type="checkbox"/> Muscle weakness      | <input type="checkbox"/> Loss of balance      | <input type="checkbox"/> Difficulty initiating movement |
| <input type="checkbox"/> Other:               |   |   |

**Endocrine:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heat or cold intolerance | <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Hormone therapy         |
| <input type="checkbox"/> Thyroid disease          | <input type="checkbox"/> Excessive hunger   | <input type="checkbox"/> Sudden weight loss/gain |
| <input type="checkbox"/> Excessive thirst         | <input type="checkbox"/> Diabetes           |  |
| <input type="checkbox"/> Excessive urination      | <input type="checkbox"/> Hypoglycemia       |  |

**Blood/Lymphatic:**

- |  |  |
|--|--|
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Past transfusions   |
| <input type="checkbox"/> Easy bleeding or bruising | <input type="checkbox"/> Lymph node swelling |

**Injuries:**

- |                                       |                                      |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Whiplash    |
| <input type="checkbox"/> Sprains      | <input type="checkbox"/> Lacerations |

**General:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fatigue/Weakness | <input type="checkbox"/> Excessive thirst    | <input type="checkbox"/> Always hungry    |
| <input type="checkbox"/> Fever/Chills     | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Loss of appetite |

**Other:**

- |  |  |
|--|--|
| <input type="checkbox"/> Binge eating/drinking             | <input type="checkbox"/> Water retention |
| <input type="checkbox"/> Crave certain foods. Please list: | <input type="checkbox"/> Anything Else?  |

**Mental/Emotional:**

- |                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Fears/Phobias please list: | <input type="checkbox"/> Decreased sexual desire     |
| <input type="checkbox"/> Anxiety     | <input type="checkbox"/> Depression                 | <input type="checkbox"/> Problems with memory        |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Insomnia                   | <input type="checkbox"/> Problems with concentration |
| <input type="checkbox"/> Tension     | <input type="checkbox"/> Anger Irritability         |  |

