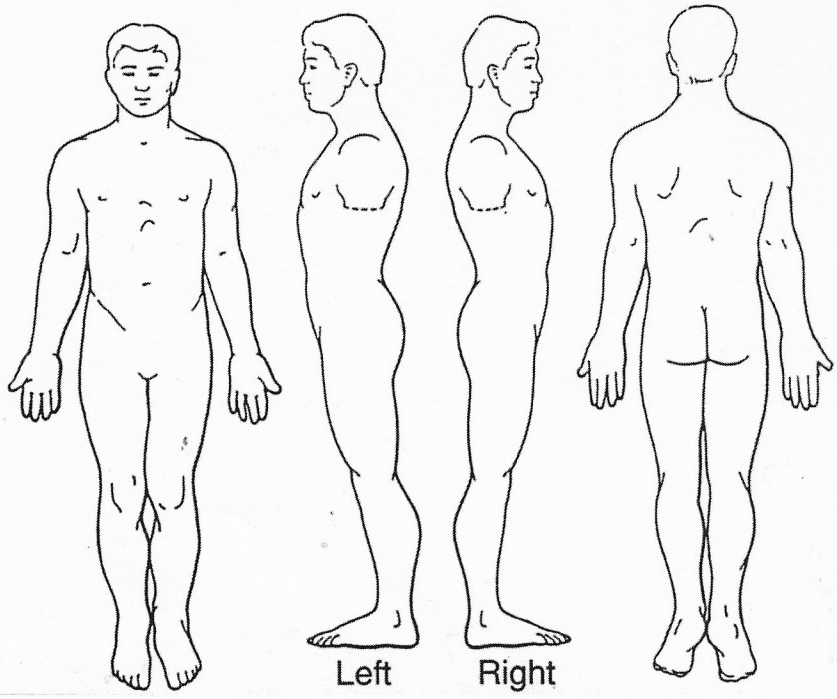
PAIN:

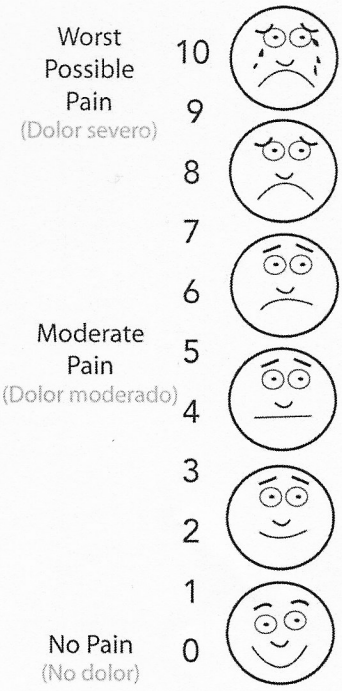
Do you have pain? □ Yes □ No

If so, please describe: _____

_____

Please indicate affected and/or painful area(s)





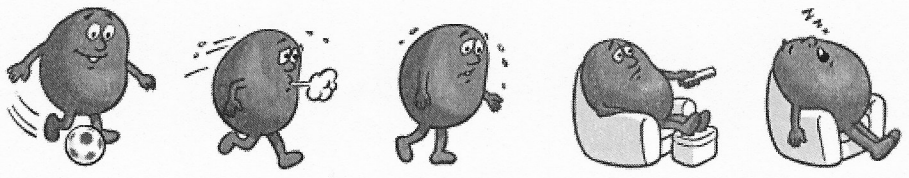
Pain	
x	Little
xx	Moderate
xxx	strong

FATIGUE:

Do you feel fatigued? □ Yes □ No

If so, please describe: _____

_____



Patient Name: _____ Date: _____

Women only:

Are you pregnant now? □ Yes □ No

Number of pregnancies:_____ Number of children:_____

Age of first period:_____ Age of menopause:_____

Is your menstrual cycle regular? □ Yes □ No □ Post-menopausal

1. Average number of days in flow:_____
2. Volume: □ Normal □ Heavy □ Light
3. Color: □ Normal □ Dark red □ Purple □ Light brown
4. Do you have the following menstruation related signs/symptoms?

□ Blood clots □ Cramps □ Nausea □ Breast distension

□ Mood changes □ Bleeding/spotting between periods

□ Heavy vaginal discharge between periods

Do you use any contraception? □ Yes □ No □ Not applicable

If Yes, please describe:_____

Libido (sex drive) is:

□ Low □ Normal □ High

Men Only

Do you experience any of the following? (*please check all that applies)*

□ Feeling coldness or numbness in the external genitalia □ Pain or swelling in testicles

□ Premature ejaculation □ Impotence/ erectile dysfunction

Libido (sex drive) is:

□ Low □ Normal □ High

MEDICATIONS

Please list all the medications you are currently taking, including all vitamins and supplements

Name of medication	Dose	Frequency

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS *Put a check mark by the symptom(s) that you are currently experiencing:*

Constitutional Symptoms
___ Fatigue / low energy
___ Poor appetite
___ Insomnia / poor sleep
___ Fever or chills
___ Night sweats
___ Heat sensation or hot flashes
___ Unexplained weight loss or weight gain
Other: _____

Allergy / Immunological
___ Hay Fever
___ Other: _____

Ear / Nose / Throat / Oral
___ Ear Infection
___ Hearing loss
___ Sinus problems
___ Sore throat
___ Oral (canker) sores
___ Bleeding, swollen painful gums
___ Halithosis (bad breath)
Other: _____

Eyes / Vision
___ Blurred / double vision
___ Eye pain
___Dryness / irritation
Other: _____

Gastrointestinal
___ Heart burn
___ Nausea / vomiting
___ Abdominal pain / cramps
___ Diarrhea
___ Constipation
___ Palpitations
___ Bleeding from rectum
___ Black sticky stools
___ Hemorrhoids
___ Change in bowel habits
Other: _____

Respiratory
___ Chronic cough
___ Chest congestion
___ Difficulty breathing / shortness of breath
___ Recurrent chest infection
___ Asthma / wheezing
Other: _____

Cardiovascular
___ Chest pain
___ High blood pressure
___ Palpitations
___ Edema / swelling
Other: _____

Neurological
___ Headaches
___ Dizziness / fainting
___ Numbness / tingling
___ Tremors
___ Seizures / epilepsy
Other: _____

Musculoskeletal
___ Joint pain / stiffness / swelling
___ Neck pain / stiffness
___ Back pain / stiffness
___ Muscle weakness
Other: _____

Endocrine
___ Excessive thirst
___ Feeling too hot / too cold
___ Diabetes
Other: _____

Urinary
___ Blood in urine
___ Bladder / kidney infection
___ Problem with urination
___ Bladder / kidney stones
Other: _____

Hematological / Lymphatic
___ Easy bruising
___ Swollen glands
___ Excessive bleeding
___ Blood clotting problems
Other: _____

Skin / Dermatological
___ Skin rash
___ Persistent itch
Other: _____

Gynecological
___ Abnormal / irregular bleeding
___ Abnormal vaginal discharge
___ Hot flashes
___ Breast lump, pain or discharge
___ Hot flashes
Other: _____

Psychological
___ Feeling sad or depressed
___ Worried / anxious
Other: _____

Patient Name: _____ Date: _____