Name: _____

Date: _____

Y = A condition you have **now**
P = A condition you have had in the **past**

GENERAL
Weight_____
Height _____
Recent weight change ☐Y ☐P
Fatigue/Weakness ☐Y ☐P

SKIN
Rashes ☐Y ☐P
Eczema, hives ☐Y ☐P
Acne, boils ☐Y ☐P
Itching ☐Y ☐P
Colour change ☐Y ☐P
Lumps ☐Y ☐P
Night sweats ☐Y ☐P
Dryness/moistness ☐Y ☐P
Temperature changes ☐Y ☐P
Nail changes ☐Y ☐P
Changes in mole ☐Y ☐P
Skin cancer ☐Y ☐P

HEAD
Headache ☐Y ☐P
Head injury ☐Y ☐P
Dizziness ☐Y ☐P
Changes in hair
Texture/quantity ☐Y ☐P

EYES
Impaired vision ☐Y ☐P
Eye pain ☐Y ☐P
Tearing/dryness ☐Y ☐P
Double vision ☐Y ☐P
Glaucoma ☐Y ☐P
Cataracts ☐Y ☐P
Blurring ☐Y ☐P
Itching ☐Y ☐P
Redness ☐Y ☐P
Discharge ☐Y ☐P
Blind spot ☐Y ☐P

EARS
Impaired hearing ☐Y ☐P
Earache ☐Y ☐P
Dizziness ☐Y ☐P
Discharge ☐Y ☐P
Infections ☐Y ☐P
Ringing ☐Y ☐P

NOSE/SINUSES
Frequent colds ☐Y ☐P
Nose bleeds ☐Y ☐P
Stuffiness ☐Y ☐P
Hay fever ☐Y ☐P
Sinus problems ☐Y ☐P
Post-nasal drip ☐Y ☐P

MOUTH/THROAT
Freq sore throat ☐Y ☐P
Sore tongue/mouth ☐Y ☐P
Gum problems ☐Y ☐P
Hoarseness ☐Y ☐P
Dental cavities ☐Y ☐P
Loss of taste ☐Y ☐P

NECK
Lumps ☐Y ☐P
Swollen glands ☐Y ☐P
Goitre ☐Y ☐P
Pain/stiffness ☐Y ☐P

RESPIRATORY
Cough ☐Y ☐P
Sputum ☐Y ☐P
Spitting up blood ☐Y ☐P
Wheezing ☐Y ☐P
Asthma ☐Y ☐P
Bronchitis ☐Y ☐P
Pneumonia ☐Y ☐P
Emphysema ☐Y ☐P
Difficulty breathing ☐Y ☐P
Pain on breathing ☐Y ☐P
Shortness of breath ☐Y ☐P
Tuberculosis ☐Y ☐P
Tuberculin Test ☐Y ☐P
Last Chest X-Ray _____

BREASTS
Do you do self exams ☐Y ☐P
Lumps ☐Y ☐P
Pain/tenderness ☐Y ☐P
Nipple discharge ☐Y ☐P

GASTROINTESTINAL
Trouble swallowing ☐Y ☐P
Heartburn ☐Y ☐P
Change in thirst ☐Y ☐P
Change in appetite ☐Y ☐P
Nausea/Vomiting ☐Y ☐P
Vomiting blood ☐Y ☐P
Blood in stool ☐Y ☐P
Belching/Flatulence ☐Y ☐P
Jaundice (yellow skin) ☐Y ☐P
Liver disease ☐Y ☐P
Gall bladder disease ☐Y ☐P
Ulcer ☐Y ☐P
Indigestion ☐Y ☐P
Diarrhea ☐Y ☐P
Constipation (less than 1 stool/day) ☐Y ☐
Rectal bleeding ☐Y ☐
Haemorrhoids ☐Y ☐
Black, tarry stool ☐Y ☐
Abdominal pain ☐Y ☐
Food allergy ☐Y ☐
Hernias ☐Y ☐

CARDIOVASCULAR
High blood pressure ☐Y ☐
Rheumatic fever ☐Y ☐
Swollen ankles ☐Y ☐
Chest pain ☐Y ☐
Palpitations ☐Y ☐
High cholesterol ☐Y ☐
Heart murmurs ☐Y ☐

URINARY
Pain on urination ☐Y ☐
Increased frequency ☐Y ☐
Frequency at night ☐Y ☐
Inability to hold urine ☐Y ☐
Frequent infections ☐Y ☐
Kidney stones ☐Y ☐
Blood in urine ☐Y ☐
Urgency ☐Y ☐
Hesitancy ☐Y ☐

MALE REPRODUCTIVE
Hernias ☐Y ☐
Testicular masses ☐Y ☐
Testicular pain ☐Y ☐
Sexual difficulties ☐Y ☐
Sexually Transmitted Infection ☐Y ☐
Discharge/sores ☐Y ☐
Date of last prostate exam _____

FEMALE REPRODUCTIVE
Age menses began _____
Average number of days _____
Length of cycle _____
Last menstrual period _____
Last PAP test (date) _____
Number of pregnancies _____
Number of miscarriages _____
Number of abortions _____
Are you sexually active ☐Y ☐
Currently pregnant ☐Y ☐
Bleeding between periods ☐Y ☐
Are cycles regular ☐Y ☐
Pain during intercourse ☐Y ☐
Painful menses ☐Y ☐
Excessive flow ☐Y ☐
PMS ☐Y ☐
Birth control (and type) ☐Y ☐

Difficulty conceiving ☐Y ☐P
Sexual difficulties ☐Y ☐P
Sexually Transmitted Infection ☐Y ☐P
Vaginal discharge ☐Y ☐P
Vaginal itching/dryness ☐Y ☐P

MUSCULOSKELETAL
Joint pain/stiffness ☐Y ☐P
Arthritis/gout ☐Y ☐P
Broken bones ☐Y ☐P
Muscle spasms/cramps ☐Y ☐P
Joint swelling ☐Y ☐P
Backache ☐Y ☐P

PERIPHERAL VASCULAR
Deep leg pain ☐Y ☐P
Cold hands/feet ☐Y ☐P
Varicose veins ☐Y ☐P
Leg cramps ☐Y ☐P
Extremity numbness ☐Y ☐P
Extremity swelling ☐Y ☐P
Extremity ulcers ☐Y ☐P

NEUROLOGIC
Fainting ☐Y ☐P
Seizures/convulsions ☐Y ☐P
Paralysis ☐Y ☐P
Muscle weakness ☐Y ☐P
Numbness/tingling ☐Y ☐P
Loss of memory ☐Y ☐P
Involuntary movement ☐Y ☐P
Loss of balance ☐Y ☐P
Speech problems ☐Y ☐P

ENDOCRINE
Heat/cold intolerance ☐Y ☐P
Thyroid trouble ☐Y ☐P
Excessive thirst/hunger ☐Y ☐P
Excessive urination ☐Y ☐P
Excessive sweating ☐Y ☐P
Diabetes ☐Y ☐P
Hypoglycemia ☐Y ☐P
Hormone therapy ☐Y ☐P

BLOOD/LYMPHATIC
Anemia ☐Y ☐P
Easy bleeding/bruising ☐Y ☐P
Past transfusions ☐Y ☐P
Lymph node swelling ☐Y ☐P

EMOTIONAL
Depression ☐Y ☐P
Mood swings ☐Y ☐P
Anxiety/nervousness ☐Y ☐P
Tension ☐Y ☐P
Phobias ☐Y ☐P
Alcohol/drug use ☐Y ☐P
Insomnia ☐Y ☐P

HOBBIES/HABITS
Do you eat 3 meals per day? ☐Y ☐N
Do you wake well rested? ☐Y ☐N
Do you sleep well? ☐Y ☐N
Do you average 6-8 hours sleep? ☐Y ☐N
Do you enjoy your work? ☐Y ☐N
Do you exercise? ☐Y ☐N

How many hours/day? _____

Use the space below if you would like to provide more details about any of the above: