Name:

Date:

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

GENERAL		
Weight	_	
Height	_	
Recent weight char	nge Y	P
Fatigue/Weakness	Υ	□P
SKIN		
Rashes		□P □P
Eczema, hives Acne, boils		
Itching		
Colour change	⊡'Y	
Lumps		DP
Night sweats		P
Dryness/moistness		
Temperature change	ges Y	P
Nail changes	Y	Р
Changes in mole	Y	П
Skin cancer	ΞY	□Р
HEAD		
Headache	Y	P
Head injury	□Y □Y	Р
Dizziness	Y	Р
Changes in hair		
Texture/quantity	ΓY	Р
EYES	_	
Impaired vision	Y	P
Eye pain	ΠY	P
Tearing/dryness	Ľ	
Double vision Glaucoma		□P □P
Cataracts		
Blurring	ΠY	
Itching	ΞÝ	
Redness		
Discharge		P
Blind spot	Y	ШР
EARS		
Impaired hearing	ΠY	Р
Earache	Y	Р
Dizziness	Y	Р
Discharge	Y	Р

Infections Ringing

### NOSE/SINUSES

Frequent colds

# P

Y

Nose bleeds
Stuffiness
Hay fever
Sinus problems
Post-nasal drip

MOUTH/THROAT

Sore tongue/mouth

Freq sore throat

Gum problems

Dental cavities

Swollen glands

Pain/stiffness

RESPIRATORY

Spitting up blood

Hoarseness

Loss of taste

NECK

Lumps

Goitre

Cough

Sputum

Wheezing

Bronchitis

Pneumonia

Emphysema

Tuberculosis

BREASTS

Lumps

Heartburn

Tuberculin Test

Last Chest X-Ray

Do you do self exams

Pain/tenderness

Nipple discharge

Change in thirst Change in appetite

Nausea/Vomiting

Jaundice (yellow skin)

Gall bladder disease

Vomiting blood

Blood in stool Belching/Flatulence

Liver disease

Indigestion

Diarrhea

Ulcer

GASTROINTESTINAL Trouble swallowing

Difficulty breathing

Shortness of breath

Pain on breathing

Asthma

Y	P
Y	P
Y	P
Υ	P
Y	P

Π	ΠP
⊡Y	
Η̈́Υ	
ΞY	
Η'	
<b></b>	

Y	Р
Y	P
Y	P
Y	P

Y	P
Y	ΠP
<b>'</b>	
Y	P
Y	P
Y	P
Y	Ρ
□Y □Y	P
Η.	
Y	P
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	P
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Y	P
Y	P
Y	ПР
	P

Y Y Y ΓY Y Y Υ Y Υ Y Y Y

Y

Υ

Y

Y

Y

Y

P

P

P

Constipation (less than 1 stool/day) Rectal bleeding Haemorrhoids Black, tarry stool Abdominal pain Food allergy Hernias

CARDIOVASCULAR

High blood pressure

Rheumatic fever

Swollen ankles

Chest pain

Palpitations

URINARY

High cholesterol

Heart murmurs

Pain on urination

Increased frequency

Inability to hold urine

Frequency at night

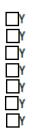
Frequent infections

Kidney stones

Blood in urine

Urgency

Hesitancy



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# Y

Y	
Y	
Y	
Y	
Y	
Y	
Y	
Y	
Y	

#### MALE REPRODUCTIVE

Hernias Testicular masses Testicular pain Sexual difficulties Sexually Transmitted

Discharge/sores 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

Y
□Y

	Υ	
	Y	
	Υ	
n		

Infecti	ion

	Υ	
tio	n	
	Y	
	Y	

Difficulty conceiving Sexual difficulties Sexually Transmitted	□Y □Y Infection	_Р _Р
Vaginal discharge Vaginal itching/dryne	□Y □Y	_р _р
vaginar terinig/ aryine	Υ	P
MUSCULOSKELETAL Joint pain/stiffness Arthritis/gout Broken bones Muscle spasms/cram	N	
Joint swelling Backache	∐Y ∐Y	□P □P
PERIPHERAL VASCUL Deep leg pain Cold hands/feet Varicose veins Leg cramps Extremity numbness Extremity swelling Extremity ulcers		
NEUROLOGIC Fainting Seizures/convulsions Paralysis Muscle weakness Numbness/tingling Loss of memory Involuntary movement Loss of balance Speech problems		ۇچو
ENDOCRINE Heat/cold intolerance Thyroid trouble Excessive thirst/hung Excessive urination Excessive sweating Diabetes Hypoglycemia Hormone therapy	Y	ۇچۈچۈ
BLOOD/LYMPHATIC Anemia Easy bleeding/bruisin Past transfusions Lymph node swelling		₽₽₽₽

#### EMOTIONAL

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

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#### HOBBIES/HABITS

Do you eat 3 meals per day?

Do you wake well rested? Do you sleep well?	
Do you average 6-8 hours s Do you enjoy your work? Do you exercise?	□N □N □N

## How many hours/day?

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