

Please circle the symptoms that are important to you in the past or present.

Weight change	Y	N	Night Sweats	Y	N
Fatigue	Y	N	Fever	Y	N
Chills	Y	N	Dizziness	Y	N
Neck Surgery	Y	N	Neck Injury	Y	N
Intolerance for heat	Y	N	Intolerance for cold	Y	N
Hypoglycemic	Y	N	Thyroid problems	Y	N
Diabetes	Y	N	Vision problems	Y	N
Hearing difficulty	Y	N	Nose bleeds	Y	N
Sinusitis	Y	N	Ringing in ears	Y	N
Sore throat	Y	N	Hoarseness	Y	N
Nausea	Y	N	Vomiting	Y	N
Difficulty swallowing	Y	N	Heartburn	Y	N
Belching	Y	N	Bloating	Y	N
Jaundice	Y	N	Constipation	Y	N
Flatulence	Y	N	Hemorrhoids	Y	N
Abdominal Surgery	Y	N	Abdominal Pain	Y	N
Gallbladder	Y	N	Indigestion	Y	N
Diarrhea	Y	N	Hernia	Y	N
Blood in stool	Y	N	Pancreatitis	Y	N
Animal bites	Y	N	Dog bite	Y	N
Bee stings	Y	N	Fainting	Y	N
Stuttering	Y	N	Wheezing	Y	N
Asthma	Y	N	Shortness of breath	Y	N
Pneumonia	Y	N	Cough	Y	N
Heart disease	Y	N	Hypertension	Y	N
Edema	Y	N	Kidney stones	Y	N
Urinary frequency	Y	N	Urinary urgency	Y	N
Urinary pain	Y	N	Urinary tract infections	Y	N
Rheumatism	Y	N	Arthritis	Y	N
Joint trouble	Y	N	Back trouble	Y	N
Pelvic pain	Y	N	Vaginal discharge	Y	N
Postcoital bleeding	Y	N	Postmenopausal bleeding	Y	N
Age period began _____			Menopausal age _____		
Menstrual duration _____			Menstrual interval _____		
Last date of period _____			Pregnancies _____ Abortions _____		
Breast lump	Y	N	Breast tenderness	Y	N
Depression	Y	N	Moles	Y	N
Anemia	Y	N	Insomnia	Y	N
Alcohol intake _____			Caffeine intake _____		
Drugs _____			Smoke _____		

Have you been immunized? _____

Any allergies to food, medications, or seasonal changes? _____

Any family history of muscular disease, cancer, kidney problems, T.B., diabetes, alcoholism, heart disease, skin disorders? Circle any that apply. Other? _____

What do you think is wrong with you? _____

How much time are you willing to spend on your health? _____

Do you remember your dreams? _____

Do you like your job? _____ What do you do? _____

Ever lived or traveled outside of the U.S.? _____ Where? _____

Operations _____

Illnesses _____

Current supplements or medications _____