

CURRENT MEDICAL STATUS

In general, I feel my overall health is: Excellent Good Fair Poor

Supplements (include brand names and dosages): *Use other side of paper if necessary*

Medications (prescription or over the counter, include dosages): _____

ALLERGIES

Drug allergies (penicillin, etc.): _____

Allergies to foods, pollens, etc.: _____

MARK THE FOLLOWING: 1 IF CURRENT, 2 IF PAST

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> ringing in ears | <input type="checkbox"/> palpitations | <input type="checkbox"/> migraines |
| <input type="checkbox"/> bronchitis | <input type="checkbox"/> sciatica | <input type="checkbox"/> tightness in chest | <input type="checkbox"/> frequent headaches |
| <input type="checkbox"/> pneumonia | <input type="checkbox"/> frequent urination | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> frequent depression |
| <input type="checkbox"/> frequent colds/flu | <input type="checkbox"/> dribbling urine | <input type="checkbox"/> severe mood swings | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> appendicitis | <input type="checkbox"/> painful urination | <input type="checkbox"/> poor sleep | <input type="checkbox"/> hemorrhoids |
| <input type="checkbox"/> Crohn's | <input type="checkbox"/> scanty urination | <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> eye problems |
| <input type="checkbox"/> gas | <input type="checkbox"/> blood in urine | <input type="checkbox"/> stomach ulcer | <input type="checkbox"/> photophobia |
| <input type="checkbox"/> diverticulitis | <input type="checkbox"/> no/low sex drive | <input type="checkbox"/> overweight | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> colitis | <input type="checkbox"/> impotence/frigidity | <input type="checkbox"/> underweight | <input type="checkbox"/> stroke |
| <input type="checkbox"/> Epstein-Barr | <input type="checkbox"/> afternoon persp/fever | <input type="checkbox"/> muscle spasms | <input type="checkbox"/> drug addiction |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> night sweats | <input type="checkbox"/> gum/teeth problems | <input type="checkbox"/> alcoholism |
| <input type="checkbox"/> HIV positive | <input type="checkbox"/> hearing problems | <input type="checkbox"/> lots of fillings | <input type="checkbox"/> other addiction |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> memory difficulty | <input type="checkbox"/> TMJ | <input type="checkbox"/> venereal disease |
| <input type="checkbox"/> mononucleosis | <input type="checkbox"/> anxiety | <input type="checkbox"/> concussion | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> allergies | <input type="checkbox"/> arthritis | <input type="checkbox"/> cancer | <input type="checkbox"/> parasites |
| | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pressure |
| | <input type="checkbox"/> epilepsy | <input type="checkbox"/> eating disorder | <input type="checkbox"/> varicose veins |
| | | | <input type="checkbox"/> phlebitis |
| | | | <input type="checkbox"/> jaundice |

To the best of your knowledge, have you ever been exposed to high doses of pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life? No Yes, please explain:

If radiation and/or chemotherapy treatments, please indicate dates, doses, agents used, and describe your experience with the treatment. Please use the back of this page.

DIET & LIFESTYLE

How are you sleeping? very well, no problems normally
 difficulty getting to sleep
 difficulty staying asleep
 difficulty waking in the morning
 groggy/sleepy during the day
 other: _____

How do you feel about the following areas of your life? (Please check appropriate boxes & make any comments)

	GREAT	GOOD	FAIR	POOR	COMMENTS
Self					
Work					
Spouse or significant other					
Sex					
Family					
Diet					

Dietary preferences/restrictions: _____

Routine physical exercise: None Yes, type: _____
 How often? _____

Tobacco use: Never
 Yes, but not any longer: How long? _____ Year quit _____
 Yes, currently: How much? _____ How long? _____
 I want to quit as soon as possible
 I have no intention of quitting

Alcohol use: How much? _____ How often? _____

Caffeine use: How much? _____ How often? _____

Other mood altering substances (past/present):
 Type: _____ How much? _____ How often? _____

Have any of these substances become a problem in your life? No Yes
 I want to quit as soon as possible
 I have no intention of quitting

FOR WOMEN ONLY!

MENSTRUAL PERIODS

Please complete this section to the best of your ability even if you no longer menstruate. It provides valuable information for an accurate assessment.

Menstruating since age: _____ Regular: No Yes

Length of cycle: _____ Flow lasts how many days? _____

Light flow Heavy Flow Clots: No Yes Color of blood: bright red dark red

Date of last menses: _____

Do you experience PMS: No Yes, describe symptoms:

Menstrual Cramps: No Yes, which days? _____

Vaginal Discharge: No Yes Color _____ Frequency _____ Amount _____

MARK THE FOLLOWING: 0 = never 1 = current 2 = past

- | | | |
|---|--|---|
| <input type="checkbox"/> hysterectomy | <input type="checkbox"/> irregular PAP smear | <input type="checkbox"/> tubal ligation |
| <input type="checkbox"/> fibroids | <input type="checkbox"/> herpes | <input type="checkbox"/> ablation |
| <input type="checkbox"/> D&C | <input type="checkbox"/> interstitial cystitis | <input type="checkbox"/> irregular bleeding |
| <input type="checkbox"/> pain with intercourse | <input type="checkbox"/> infertility | <input type="checkbox"/> breast cancer |
| <input type="checkbox"/> dryness with intercourse | <input type="checkbox"/> endometriosis | <input type="checkbox"/> mastectomy |
| <input type="checkbox"/> HPV | <input type="checkbox"/> other _____ | |

DO YOU HAVE BREAST IMPLANTS: No Yes; If yes, any problems?

PREGNANCY/BIRTH CONTROL

Are you pregnant now No Yes

Do you think you may be No Yes

Number of pregnancies _____

Number of children _____

Terminations _____

Miscarriages _____

Tubular pregnancies _____

Difficulty in conceiving No Yes

Birth control method(s):

MENOPAUSE

No menses since _____

Describe any experiences/symptoms you are feeling/having

List any hormones you are taking including dose and brand