

Habits: Please mark any of the habits listed below which apply to you.

Mark an X for current habits. Mark a √ for past habits.

Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, # of cigarettes / day _____	age started _____
Alcohol use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, # of drinks / week _____	age started _____
Caffeine use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	# of soda/day _____ # coffee /day _____	# tea /day _____
Drug use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type(s)Amount / Age started: _____	
Do you exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What type of exercise and how often? _____	

Please check the appropriate boxes below for any symptoms you have recently experienced.

HEAD & NECK

- Dizziness
- Fainting
- Neck stiffness
- Enlarged lymph glands
- Headaches
- Other _____

EARS

- Infection
- Pain
- Ringing
- Decreased hearing
- Other _____

EYES

- Blurred vision
- Visual changes
- Spots
- Eye inflammation
- Other _____

NOSE, THROAT, & MOUTH

- Bleeding
- Sinus infection
- Hay fever or allergies
- Sore throat
- Hoarseness
- Difficulty swallowing
- Changes in taste
- Changes in smell
- Oral ulcers
- Other _____

SKIN

- Hives
- Rashes
- Eczema
- Itching
- Night sweating
- Excessive sweating
- Dryness
- Bruise easily
- Changes in moles or lumps
- Other _____

RESPIRATORY

- Chronic cough
- Coughing up blood
- Coughing up phlegm
- Difficulty breathing
- Wheezing /asthma
- Frequent colds
- Other _____

CARDIO-VASCULAR

- Palpitations
- Chest pain or tightness
- Rapid heart beat
- Irregular heart beat
- Cold hands / feet
- Swelling of ankles
- Phlebitis
- Other _____

GASTROINTESTINAL

- Indigestion
- Bloating
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Nausea
- Vomiting
- Vomiting blood
- Blood in stool or black stools
- Hemorrhoids
- Gall bladder disorder
- Recent change in weight
- Food cravings
- Other _____

NEUROLOGICAL

- Seizures
- Tremors
- Numbness or tingling of limbs
- Paralysis
- Other _____

MUSCLE & JOINT

- Joint disorder
- Sore or painful muscles
- Weak muscles
- Difficulty walking
- Spinal curvature
- Backache or pain
- Other _____

UROGENITAL

- Pain / itching of genitalia
- Genital lesions / discharge
- Painful urination
- Frequent urination
- Excessive or scanty urination
- Blood in urine
- Diminished bladder control
- Other _____

FEMALE

- Frequent urinary tract infections
- Frequent vaginal infections
- Pelvic inflammatory disease
- Abnormal Pap smear
- Uterine fibroids
- Irregular periods
- Painful menstrual periods
- Premenstrual Syndrome
- Abnormal bleeding
- Menopausal symptoms
- Breast pain
- Breast lumps
- Nipple discharge
- Other _____

First day of last menstrual cycle: _____

Date of last Pap smear: _____

Were Pap smear results normal?

Yes No _____

Date of last mammogram: _____

Are you pregnant? Yes No

Are you nursing? Yes No

Do you use birth control?

Yes T type: _____ No

MALE

- Lumps in testicles
- Prostate problems
- Weak urinary stream
- Impotence
- Other _____

OTHER

- Insomnia
- Frequent dreams / nightmares
- Anxiety
- Irritability
- Forgetfulness
- Depression
- Fatigue
- Decreased libido
- Feel hot or cold
- Aversion to heat or cold
- Fever and or chills
- Thirst
- Psychiatric treatment
- Other _____

Please list any other symptoms not covered above: _____