

DATE OF INITIAL VISIT:

PATIENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Street Address:		City:
Postal Code:	Home phone number:	Daytime phone number:
May we leave messages relating to your visits: <input type="checkbox"/> Yes <input type="checkbox"/> No		Email:
Date of Birth: (MM/DD/YYYY)	Sex: <input type="checkbox"/> F <input type="checkbox"/> M	How did you hear about us?
EMERGENCY CONTACT INFORMATION		
Last Name:	First Name:	Relationship:
Daytime phone number:		Evening phone number:
OTHER HEALTH CARE PROVIDERS		
1. Name & designation: Phone number: Address:	2. Name & designation: Phone number: Address:	3. Name & designation: Phone number: Address:
Date of last visit to medical doctor: Are you currently under his/her care? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you been to an ND before? <input type="checkbox"/> Yes <input type="checkbox"/> No

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON WITHOUT YOUR CONSENT. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

HEALTH HISTORY QUESTIONNAIRE

Health concerns (or reasons for your visit to the clinic) in order of importance to you:

1.	
2.	
3.	
4.	
Date of last physical exam:	How would you rate your health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Immunizations: <input type="checkbox"/> Tetanus <input type="checkbox"/> Smallpox <input type="checkbox"/> DPT (diphtheria, polio, tetanus) <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Chickenpox <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Influenza (flu shot) <input type="checkbox"/> MMR (measles, mumps, rubella)	
Any adverse reactions?	
Childhood illnesses: <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Chickenpox <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio <input type="checkbox"/> TB <input type="checkbox"/> Other _____	

List any medical conditions that other doctors have diagnosed (present/past):

1.
2.
3.
4.
5.

Please indicate any serious illnesses/conditions/surgeries or reasons for hospitalizations:

Date of diagnosis	Illness/medical condition/surgery/hospitalization	Is the condition still present?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

Screening Tests: Please indicate which of the following screening tests do you receive (if known)

Test		How often?
PAP test	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never	
Breast Exam	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never	
Mammogram	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never	
DEXA Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never	
Digital Rectal Exam (males)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never	
PSA (males)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never	
Cholesterol/CBC/blood glucose	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never	
Eye exams	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Never	

List your prescribed drugs, over-the-counter medications and supplements, (pain killers, vitamins, herbs, allergy meds etc)

Medication/Supplement	Prescribing Physician	Dosage/day	Date started	Condition it's treating
Have you taken antibiotics within the last 5 years ? <input type="checkbox"/> Yes <input type="checkbox"/> No			Were you frequently given anti-biotics as a child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How many times have you taken anti-biotics within the last 5 years? For what conditions?				

Please list all allergies (medications, foods, supplements, environmental, etc...)

Name of allergen:	Reaction you had and severity of reaction:

HEALTH HABITS

Exercise	<input type="checkbox"/> Sedentary (No exercise)	
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)	
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation at least 3x/week for 30 minutes)	
Diet	Are you dieting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?	
	Dietary restrictions? (Religious, vegetarian, vegan?)	
	Rank salt intake	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
	Rank fat intake	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
	Rank carbohydrate intake	<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola <input type="checkbox"/> Diet soda	
	# of cups/cans per day?	
Alcohol	Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many drinks per week?	
Tobacco	Are you exposed to second hand smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Other (add amount)
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit
Lifestyle	How would you currently rate your level of stress? <input type="checkbox"/> Minimal <input type="checkbox"/> Average <input type="checkbox"/> Considerable <input type="checkbox"/> Unbearable	
	What are the major causes of stress in your life at this time: <input type="checkbox"/> financial <input type="checkbox"/> career <input type="checkbox"/> personal <input type="checkbox"/> marriage/relationship <input type="checkbox"/> health <input type="checkbox"/> family <input type="checkbox"/> spiritual <input type="checkbox"/> other	
	How does your stress manifest itself:	
	What type of coping mechanism to you employ to manage your stress?	
Drugs	Do you currently use recreational drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Laxatives?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Diet Pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you sexually active?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:	
	Any discomfort or bleeding with intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No

FAMILY HEALTH HISTORY

INCLUDING: ALLERGIES, ASTHMA, HEART DISEASE, HIGH BLOOD PRESSURE, CANCER, DIABETES, DEPRESSION (INCLUDING POST-PARTUM) OTHER MENTAL ILLNESS, DRUG ABUSE, ALCOHOLISM, KIDNEY DISEASE AND ANY OTHER RELEVANT HEALTH PROBLEMS.					
	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			CHILDREN		<input type="checkbox"/> M <input type="checkbox"/> F
MOTHER					<input type="checkbox"/> M <input type="checkbox"/> F
SIBLINGS		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F
		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F
GRANDMOTHER (maternal)				GRANDMOTHER (paternal)	
GRANDFATHER (maternal)			GRANDFATHER (paternal)		
<input type="checkbox"/> I don't know my family history					

REVIEW OF SYSTEMS

BESIDE EACH ITEM, PLEASE CHECK Y (YES), N (NO), OR P (PAST).

SKIN	
Rashes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Eczema	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hives	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Acne or boils	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Itching	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Colour change	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Dryness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Moistness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Nail changes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Changes in mole(s)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Skin cancer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Night sweats	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/NOTES:	

EYES	
Impaired vision	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Eye pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Tearing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Dryness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Double vision	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cataracts	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Blurring	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Bothered by sun	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Itching	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Redness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Blind spot	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/NOTES:	

HEAD	
Headache	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Head injury	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/NOTES:	

EARS	
Impaired hearing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Earache	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Infections	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/NOTES:	

NOSE AND SINUSES	
Frequent colds	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Nose bleeds	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Stuffiness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hayfever	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sinus problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/NOTES:	

MOUTH AND THROAT	
Frequent sore throat	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sore tongue or mouth	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Gum problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Dental cavities	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Loss of taste	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sores in and around the mouth	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/NOTES:	

NECK	
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Swollen glands	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Goiter	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Pain or stiffness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/NOTES:	

RESPIRATORY	
Cough	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sputum/phlegm	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Difficulty breathing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Pain on breathing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Last tuberculin test	
Last chest xray	
Other/NOTES:	

CARDIOVASCULAR	
Heart disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Angina	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Murmurs	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Rheumatic fever	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Chest pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Swelling in ankles	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Palpitations/fluttering	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cyanosis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/NOTES:	
Past ECG	
Other heart tests	

BREAST	
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Pain or tenderness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Nipple discharge	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Do you do self-breast exams?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

GASTROINTESTINAL	
Trouble swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Heartburn	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Change in thirst	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Change in appetite	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Nausea	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Vomiting blood	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Blood in stool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Belching or passing gas	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Gallbladder disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Jaundice (yellow skin)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Ulcer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Indigestion	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Rectal bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hemorrhoids	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Black tarry stool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Light grey stool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hernias	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Bowel movements (how often?)	
Is this a change?	
Other/NOTES:	

URINARY	
Pain on urination	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Increased frequency	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequency at night	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Inability to hold urine	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent urinary infections	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Kidney stones	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Blood in urine	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Urgency	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hesitancy	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/NOTES:	

MUSCULOSKELETAL	
Joint pain or stiffness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Broken bones	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Muscle spasms or cramps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Weakness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Joint swelling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Backache	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/NOTES:	

PERIPHERAL VASCULAR	
Deep leg pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cold hands and feet	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Varicose veins	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Thrombophlebitis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Leg cramps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Extremity numbness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Extremity swelling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Extremity ulcers	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/NOTES:	

NEUROLOGICAL	
Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Seizures/convulsions	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Paralysis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Muscle weakness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Numbness or tingling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Loss of memory	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Involuntary movement	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Loss of balance	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Speech problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/COMMENTS:	

ENDOCRINE	
Excessive thirst	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Excessive urination	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Excessive sweating	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Excessive hair growth	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/COMMENTS:	

BLOOD AND LYMPHATICS	
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Easy bleeding or bruising	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Lymph node swelling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/COMMENTS:	

EMOTIONAL	
Depression	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Mania	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Mood swings	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Anxiety and nervousness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Phobias	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Insomnia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Other/COMMENTS:	

FEMALE	
Age at onset of menstruation:	_____
Date of last menstruation:	_____
Period every _____ days	
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Number of pregnancies _____ Number of live births _____	
Are you pregnant or breastfeeding?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Any urinary tract, bladder, or kidney infections within the last year?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Any blood in your urine?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Any problems with control of urination?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Any hot flashes or sweating at night?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Date of last pap?	

MALE	
Do you usually get up to urinate during the night?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
If yes, # of times _____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Do you feel pain or burning with urination?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Any blood in your urine?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Do you feel burning discharge from penis?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Has the force of your urination decreased?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Any testicle pain or swelling?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Date of last prostate and rectal exam?	

THANK YOU FOR COMPLETING THE FORM!
IT WILL HELP YOUR DOCTOR GAIN MORE INSIGHT ON YOUR ENTIRE CASE