

San Francisco Natural Medicine

Patient History & Symptom Review

Please Note: 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 except when you have authorized us to do so.

Name _____ Date _____
 Street _____ Home Phone _____
 City _____ St ____ Zip _____ Work Phone _____
 Age _____ Birth Date _____ E-mail address _____
 M F Height _____ Weight _____ Social Security # _____
 Employer _____ Occupation _____
 Name of person we should contact in event of an emergency:
 Name _____ Home Phone _____
 Relationship _____ Work Phone _____
 How were you referred to this clinic? _____

MAIN REASON FOR COMING _____

When did it begin? (Date) _____ What caused it? _____
 Work-related? Y N DK Accident? Y N What kind? _____
 What makes it better? heat cold activity rest other _____
 What makes it worse? heat cold activity rest other _____
 Is it getting worse? Y N Does it interfere with? work sleep daily routine
 Have you received treatment for this problem? Y N If yes:

Who?	When?	Treatment	Did it help?
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>
_____	_____	_____	Y <input type="checkbox"/> N <input type="checkbox"/>

OTHER REASONS FOR COMING

1. _____
2. _____
3. _____

OTHER HEALTH ISSUES/GOALS

Improve energy levels Gain or lose weight Improve immunity Clear skin
 Improve diet/nutrition Reduce reliance on _____ (caffiene, tobacco, etc.)
 I am interested in the following modalities to meet my health goals:
 Acupuncture Naturopathic Medicine Herbal medicine Nutritional Support Massage/Bodywork

OVERALL HEALTH

Considering your age, how would you describe your overall health? Excellent Good Fair Poor
 In general, how satisfied are you with your life? Very satisfied Mostly satisfied Mostly disappointed

PERSONAL HEALTH HISTORY

ILLNESSES/INJURIES

Have you ever had the following? Check all that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Influenza | <input type="checkbox"/> Prostate problems |
| <input type="checkbox"/> Arthritis/gout | <input type="checkbox"/> Dislocations | <input type="checkbox"/> Kidney/bladder problems | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Lifting injuries | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Auto accident/injury | <input type="checkbox"/> Eczema/hives | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Bleeding/bruising problem | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Migraines | <input type="checkbox"/> Sprains |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Food, chemical, or drug poisoning | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Ulcers/stomach disease |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gallstones/gallbladder disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Neuritis or neuralgia | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hepatitis A B C | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Colitis or bowel disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Convulsions/epilepsy | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Pneumonia | |

When was your last:

Physical exam	Date _____	Results _____
Chest X-Ray	Date _____	Results _____
Skin exam	Date _____	Results _____
EKG	Date _____	Results _____
Other	Date _____	Results _____

ALLERGIES/SENSITIVITIES

Check all that apply:

- | | | | |
|----------------------------------|---------------------------------|--------------------------------|--|
| Dairy <input type="checkbox"/> | Molds <input type="checkbox"/> | Smoke <input type="checkbox"/> | Penicillin <input type="checkbox"/> |
| Citrus <input type="checkbox"/> | Dust <input type="checkbox"/> | Grass <input type="checkbox"/> | Aspirin <input type="checkbox"/> |
| Wheat <input type="checkbox"/> | Weeds <input type="checkbox"/> | Trees <input type="checkbox"/> | Codeine or morphine <input type="checkbox"/> |
| Alcohol <input type="checkbox"/> | Pollen <input type="checkbox"/> | Fumes <input type="checkbox"/> | Other _____ |

BLOOD TYPE

Do you know your blood type? O A B AB Don't know

HOSPITALIZATIONS/SURGERIES

Have you been hospitalized for any illness? N Y

Reason _____ Month/Year _____ Where _____
 Reason _____ Month/Year _____ Where _____

Have you ever had surgery? Give year or age:

Tonsils _____	Appendix _____	Hysterectomy _____	Gall Bladder _____
Kidney _____	Heart _____	Hernia _____	Back/spine _____
Prostate _____	Cyst _____	Cancer _____	Breast _____

Other _____
 Have you ever had a blood or plasma transfusion? N Y

FOREIGN TRAVEL

Travel in the past ten years: Location _____ Year _____ Location _____ Year _____

FAMILY HISTORY

	If Living		If Deceased		Has any blood relative ever had:	Who?
	Age	Health	Age/Death	Cause		
Father	_____	_____	_____	_____	Cancer	_____
Mother	_____	_____	_____	_____	Tuberculosis	_____
Sibling	_____	_____	_____	_____	Diabetes	_____
Sibling	_____	_____	_____	_____	Heart Trouble	_____
Sibling	_____	_____	_____	_____	High Blood Pressure	_____
Sig. Other	_____	_____	_____	_____	Stroke	_____
Children	_____	_____	_____	_____	Epilepsy	_____
Children	_____	_____	_____	_____	Suicide	_____
Children	_____	_____	_____	_____	Other	_____

EXERCISE

I exercise _____ days/week. Activities _____
 Are you satisfied with your level of fitness? Y N
 What physical activities do you enjoy doing or are interested in? _____

SLEEP

How many hours of sleep do you usually get a night? _____ Do you sleep well? Describe _____
 Do you wake feeling refreshed? Always Usually Rarely Never

REVIEW OF SYSTEMS

If you have the symptoms below, please check the box that best describes their severity. If you had the symptom in the past, check the box. If you have the symptom currently, circle the box like this: If you don't have symptoms, leave blank.

1 = mild/sometimes 2 = moderate/often 3 = severe/constant

GENERAL

	1	2	3		1	2	3		1	2	3
Unintentional weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel warmer than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained fevers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strong thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feel colder than others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusual or unexplained fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Accident prone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusual or increased bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unusual skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

MUSCULOSKELETAL

Aching muscles or joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain or swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bones painful or sore	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problems walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unable to sit straight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle jerking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss in height	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbow pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wrist pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Knee pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hip pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								

EYES, EARS, NOSE, THROAT

Eye pain or itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ring in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain on swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Toothache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
See halos or lights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Discharge from ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic sore tongue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wear glasses or contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Repeated nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore or bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watering eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic nose obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarse voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strange odors or taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

HEART, CIRCULATION & LUNGS

Difficult breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sit up to breathe easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing or gasping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid/skipped beats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen feet or ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps walking or at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain on effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily sputum production	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Catch colds easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

THYROID

Swollen or bulging eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gain weight easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strong urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold hands/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble awakening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thick skin/fingernails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GASTROINTESTINAL

Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gray/whitish stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucus in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent belching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alt. loose stools/constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal itch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach pain w/stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea or loose stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain/cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Black stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food allergies; list foods											

LIVER/GALL BLADDER

Skin turns yellow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Floating stools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin itches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insensitive to medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain under right ribcage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intolerance of fatty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches after eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

KIDNEYS & BLADDER

Frequent or excess urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain with urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scanty urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retention of urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Burning on urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constant urge to urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty starting urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leakage of urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wake up to urinate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brown, black or bloody urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

SKIN

	1	2	3		1	2	3		1	2	3
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Purpura	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dandruff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	Y <input type="checkbox"/>	N <input type="checkbox"/>	
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Any recent skin or hair changes? _____
 Any unusual skin problems or sores? _____
 Any sores which will not heal or bleed easily? Where? _____

EMOTIONS

Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopeless outlook	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lonely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dislike criticism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily stressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever attempted suicide? Y N

How close are your social ties with family and friends? Very close Somewhat close Somewhat distant Very distant

Are you involved in an abusive relationship? Y N Have you been physically, sexually or emotionally abused in the past? Y N

Have you ever been treated for mental or emotional problems? Y N

MEN'S HEALTH

Burning or discharge from penis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Premature ejaculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Painful testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sores on penis or scrotum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Erection problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps or swelling on testicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins in scrotum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ejaculation pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low sperm count	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Do you do regular scrotum self exams? Y N How often? _____

WOMEN'S HEALTH**Menstrual History**

Age started menstruation _____ Date of most recent period _____ Do you use: tampons pads

Are your periods regular? Y N Days between periods _____ Period lasts _____ days

Bleeding is: light medium heavy Do you bleed between periods? Y N

Do you have painful periods? N Yes: mild medium severe

Do you have pelvic inflammatory disease? Y N Do you have unusual vaginal discharge? Y N Describe _____

Do you have recurrent vaginal/bladder infections? Y N

When was your last: gynecological exam _____ Pap smear _____ Mammogram _____ Breast exam _____

Have you ever had an abnormal Pap or mammogram? Describe _____

Do you perform regular breast self-exams? Y N How often? _____ Any breast masses? Y N

Any nipple discharge? Y N Have you been told you are going or have you gone through menopause? Y N

Menstrual Symptoms

Is PMS a health issue for you? Y N

	1	2	3		1	2	3		1	2	3
Nervous tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweet cravings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Increased appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart pounding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness or faintness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Birth Control

What methods of birth control are you now using or have used in the past? Check all that apply.

Birth control pills	Now <input type="checkbox"/>	Past <input type="checkbox"/>	When taken? _____
IUD	Now <input type="checkbox"/>	Past <input type="checkbox"/>	Diaphragm _____ Now <input type="checkbox"/> Past <input type="checkbox"/>
Condoms	Now <input type="checkbox"/>	Past <input type="checkbox"/>	Cervical cap _____ Now <input type="checkbox"/> Past <input type="checkbox"/>
Foam	Now <input type="checkbox"/>	Past <input type="checkbox"/>	Tubal ligation _____ Now <input type="checkbox"/> Past <input type="checkbox"/>
Rhythm method	Now <input type="checkbox"/>	Past <input type="checkbox"/>	Partner is sterile or vasectomy _____ Now <input type="checkbox"/> Past <input type="checkbox"/>
None	<input type="checkbox"/>		Not applicable <input type="checkbox"/>

Birth History

Number of pregnancies _____ Number of children _____

Type of delivery: Vaginal _____ Caesarean _____

Did you breast feed your babies? Y N