

Health History continuedCheck **symptoms** you have or have had in the past year:**MUSCLE/BONE/JOINTS**

- Tremors Swollen joints
 Cramps Restless leg

Pain, weakness, numbness or tingling in:

- Neck Back
 Shoulders Hip
 Arms Legs
 Hands Feet
 Other _____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- Asthma/wheezing Hay fever
 Blurred/failing vision Hoarseness
 Cough/sore throat Gum bleeding
 Hearing loss Labored breathing
 Earache Nose bleeds
 Enlarged glands Persistent cough
 Eye pain Ringing in ears
 Frequent colds Sinus problems
 Other _____

SKIN

- Acne Itching/rash
 Boils Psoriasis
 Bruise easily Sensitive Skin
 Dandruff Skin Cancer
 Dry skin Sore won't heal
 Eczema Sweats
 Other _____

GENITO/URINARY

- Bladder infection Kidney stones
 Blood/Pus in urine Lowered libido
 Frequent urination Painful urination
 Incontinence Urine stream stopping
 Kidney infection
 Other _____

CARDIOVASCULAR

- Angina Pain over heart
 Chest pain Poor circulation
 Hardening of arteries Heart attack
 High cholesterol Rapid heart beat
 High blood pressure Swelling of ankles
 Irregular heart beat
 Other _____

GASTROINTESTINAL

- Acid reflux Excessive hunger
 Belching Gall Bladder trouble
 Black/tarry stool Hemorrhoids
 Blood in stool Indigestion
 Colitis/IBS Nausea
 Constipation Pain over stomach
 Diarrhea Poor appetite
 Gas/bloating Trouble swallowing
 GERD Vomiting
 Other _____

FOR MEN ONLY

- BPH Erection difficulty
 Dribbling urine Prostate cancer
 Delayed stream Prostate enlarged
 Other _____

FOR WOMEN ONLY

- Bleeding between periods Breast lumps
 Clots with menses Breast cancer
 Excessive flow Endometriosis
 Scanty flow Fibroids
 Severe menstrual pain Ovarian cysts
 Irregular cycle PMS
 Menopause PID
 Miscarriage
 Other _____

Could you be pregnant? Yes No

Signature

The information on this form is correct to the best of my knowledge:

Signature: _____

Date: _____