

For Women

Age of 1st period (menarche) _____ Are you pregnant? Yes No # of pregnancies _____

Age of last period (menopause) _____ # of live births _____ # of Abortions _____ # of Miscarriages _____

Number of days between periods _____ Date of last: Gynecologic exam _____ Pap Smear _____

Number of days of flow _____ Mammogram _____ Bone Density Scan _____

Color of flow _____ Results _____

Clots? Yes No Color _____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID Other _____

Location of Pain: Lower abdomen Lower back Thighs Other _____

Nature of Pain (Please indicate before, during or after menses) Other Symptoms related to menses

Cramping _____	Stabbing _____	<input type="checkbox"/> Discharge	<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Headache
Burning _____	Aching _____	<input type="checkbox"/> Nausea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Diarrhea
Dull _____	Bloating _____	<input type="checkbox"/> Swollen breasts	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Ravenous appetite
Consistent _____	Intermittent _____	<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Night sweats
Bearing down sensation _____		<input type="checkbox"/> Increased libido	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Insomnia

For Men

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____

Lab results _____

Frequency of Urination: daytime _____ nighttime _____ Color of urine: clear murky odor: _____

Symptoms related to prostate

<input type="checkbox"/> prostate problems	<input type="checkbox"/> Delayed stream	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Retention of Urine
<input type="checkbox"/> Rectal dysfunction	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/> Impotence
<input type="checkbox"/> Back pain	<input type="checkbox"/> Groin pain	<input type="checkbox"/> Testicular pain	other _____	

Symptom Survey (For Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
 no mark () = never experience check mark (✓) = sometimes experience plus sign (+) = frequently experience

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|---|---|--|---|
| <input type="checkbox"/> lack of appetite | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> eye problems | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> excessive appetite | <input type="checkbox"/> chest pain | <input type="checkbox"/> jaundice (yellowish eyes or skin) | <input type="checkbox"/> edema |
| <input type="checkbox"/> loose stool or diarrhea | <input type="checkbox"/> sciatic pain | <input type="checkbox"/> difficulty digesting oily foods | <input type="checkbox"/> blood in stool |
| <input type="checkbox"/> digestive problems, indigestion | <input type="checkbox"/> headaches | <input type="checkbox"/> gall stones | <input type="checkbox"/> black tarry stool |
| <input type="checkbox"/> vomiting | <input type="checkbox"/> pain or coldness in the genital area | <input type="checkbox"/> light colored stool | <input type="checkbox"/> easily bruised |
| <input type="checkbox"/> belching, burping | <input type="checkbox"/> cough | <input type="checkbox"/> soft or brittle nails | <input type="checkbox"/> difficult to stop bleeding |
| <input type="checkbox"/> heartburn/reflux | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> easily angered or agitated | <input type="checkbox"/> asthma |
| <input type="checkbox"/> feeling the retention of food in the stomach | <input type="checkbox"/> decreased sense of smell | <input type="checkbox"/> difficulty in making plans or decisions | <input type="checkbox"/> tendency to catch colds easily |
| <input type="checkbox"/> tendency to become obsessive in work, relationships... | <input type="checkbox"/> nasal problems | <input type="checkbox"/> spasms or twitching of muscles | <input type="checkbox"/> intolerance to weather changes |
| | <input type="checkbox"/> skin problems | | <input type="checkbox"/> allergies |
| | <input type="checkbox"/> feeling of claustrophobia | | <input type="checkbox"/> hay fever |
| <input type="checkbox"/> insomnia, difficulty sleeping | <input type="checkbox"/> bronchitis | <input type="checkbox"/> low back pain | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> heart palpitations | <input type="checkbox"/> colitis or diverticulitis | <input type="checkbox"/> knee problems | <input type="checkbox"/> tendency to faint easily |
| <input type="checkbox"/> cold hands and feet | <input type="checkbox"/> constipation | <input type="checkbox"/> hearing impairment | <input type="checkbox"/> high cholesterol levels |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> ear ringing | <input type="checkbox"/> sudden weight loss |
| <input type="checkbox"/> mentally restless | <input type="checkbox"/> recent use of antibiotics | <input type="checkbox"/> kidney stones | |
| <input type="checkbox"/> laughing for no apparent reason | | <input type="checkbox"/> decreased sex drive | |
| <input type="checkbox"/> angina pains | | <input type="checkbox"/> hair loss | |
| | | <input type="checkbox"/> urinary problems | |