HEALTH QUESTIONNAIRE (Continued)

**ARE YOU EXPERIENCING ANY OF THE FOLLOWING:**

CONSTITUTIONAL SYMPTOMS GENITOURINARY

Unexplained weight gain or loss ……………. Yes No Frequent urination ……………………………Yes No

Fever or chills ……………………………………….. Yes No Burning or painful urination ……………..Yes No

Night sweats/Hot flashes ………………………. Yes No Blood in urine ……………………………………Yes No

Fatigue ………………………………………………….. Yes No Urination at night (> 1/night)? ………….Yes No

Incontinence or dribbling ………………… Yes No

HEMATOLOGIC/LYMPHATIC Decrease in urine stream ………………… Yes No

Bleeding or bruising tendency ………………. Yes No Kidney stones ………………………………….. Yes No

Anemia …………………………………………………. Yes No Sexual difficulty ……………………………….. Yes No

Slow to start/stop urination …………….. Yes No

EYES Female – pain with periods ……………… Yes No

Blurred or double vision …………………………. Yes No Female – irregular periods ………………. Yes No

Female – Contraception type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EARS/NOSE/MOUTH/THROAT Female – Days in menstrual cycle \_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing loss or ringing …………………………. Yes No Female – Date of last menstrual period \_\_\_\_\_\_\_\_

Earaches or drainage ……………………………. Yes No

Chronic sinus problem or rhinitis …………. Yes No MUSCULOSKELETAL

Recurrent nose bleeds …………………………. Yes No Joint pain ……………………………………….. Yes No

Bleeding gums ……………………………………… Yes No Joint stiffness or swelling ……………….. Yes No

Sore throat or voice change (hoarseness). Yes No Back pain ……………………………………….. Yes No

Hay fever ………………………………………………. Yes No

INTEGUMENTARY (skin, breast)

CARDIOVASCULAR Rash or itching ………………………………... Yes No

Heart trouble ………………………………………… Yes No Breast pain ……………………………………… Yes No

Chest pain or angina pectoris ……………….. Yes No Breast lump …………………………………….. Yes No

Palpitation (fast or irregular heart beat) .. Yes No Breast discharge ……………………………… Yes No

Shortness of breath while walk/lying flat . Yes No

Swelling of feet, ankles or hands …………… Yes No NEUROLOGICAL

High blood pressure ………………………………. Yes No Frequent or recurring headaches …… Yes No

Lightheaded or dizzy ………………………. Yes No

RESPIRATORY Convulsions or seizures ………………….. Yes No

Chronic or frequent coughs ………………….. Yes No Numbness or tingling sensations ……. Yes No

Spitting up blood ………………………………….. Yes No Paralysis …………………………………………. Yes No

Shortness of breath ……………………………… Yes No Memory loss or confusion ………………. Yes No

Asthma or wheezing …………………………….. Yes No

ENDOCRINE

GASTROINTESTINAL Thyroid disease ………………………………. Yes No

Loss of appetite ……………………………………. Yes No Diabetes …………………………………………. Yes No

Change in bowel movements ………………. Yes No Other glandular or hormone problem Yes No

Nausea or vomiting ……………………………… Yes No

Frequent diarrhea ……………………………….. Yes No OTHER

Painful bowel movements or constip……. Yes No Nervousness …………………………………… Yes No

Rectal bleeding or blood in stool …………. Yes No Depression/Anxiety/Panic ……………… Yes No

Abdominal pain or heartburn ………………. Yes No Insomnia ……………………………………….. Yes No

Peptic ulcer (stomach or duodenal) …….. Yes No

Trouble swallowing ……………………………… Yes No Other concerns not noted above:

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Physician Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_