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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_