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Medical and Symptom History

Please list all your current doctors: _____

_____

Please list all current medications: _____

_____

For Females

Age of first menstrual cycle: _____Last menstrual cycle: _____

How many times have you been pregnant?_____Births? _____

How many miscarriages have you had? _____Abortions? _____

Please check all conditions you have had or are having

- ☐ Amenorrhea (lack of menstruation)
- ☐ Cancer
- ☐ Endometriosis
- ☐ Infertility
- ☐ Menstrual problems
- ☐ Ovarian cysts
- ☐ Pelvic scarring Menopause
- ☐ Uterine fibroids

Surgeries

Please check **all** surgeries you have had.

- ☐ Angioplasty
- ☐ Appendectomy
- ☐ Cosmetic surgery
- ☐ Dilation and Curettage (D&C)
- ☐ Gallbladder surgery
- ☐ Heart bypass
- ☐ Hernia surgery
- ☐ Hysterectomy
- ☐ Tonsillectomy
- ☐ Other: _____

Conditions

Please check **all** medical conditions you **have had** or **are having**.

- ☐ ADD/ADHD
- ☐ AIDS/HIV Positive
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Brain Injury
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Meningitis
- ☐ Migraine Headaches
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pelvic Inflammatory Disease
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Rheumatic Fever
- ☐ Scoliosis
- ☐ Sexually Transmitted Disease
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: _____

Current Medical Symptoms

Please check **all** of the following symptoms you **are having** or **have had** in the last **six months**.

⇨ General
- ☐ Chills/Fever
- ☐ Decreased energy
- ☐ Difficulty concentrating
- ☐ Difficulty sleeping
- ☐ Easily upset/irritated
- ☐ Fainting/Dizziness
- ☐ Frequent nightmares
- ☐ Frequently nervous
- ☐ Sadness/Crying
- ☐ Weight gain
- ☐ Weight loss

⇨ Eyes/Ears/Nose/Throat
- ☐ Blurred vision
- ☐ Decreased hearing
- ☐ Double vision
- ☐ Earache
- ☐ Eye pain
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Runny nose
- ☐ Sinus problems

⇨ Cardiovascular
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Heart palpitations
- ☐ Heart problem
- ☐ High blood pressure
- ☐ Irregular heartbeats
- ☐ Leg cramps
- ☐ Shortness of breath
- ☐ Swollen ankles

⇨ Respiratory
- ☐ Asthma
- ☐ Coughing
- ☐ Coughing blood
- ☐ Positive TB skin test
- ☐ Shortness of breath
- ☐ Tuberculosis

⇨ Gastrointestinal
- ☐ Abdominal pain
- ☐ Abdominal swelling
- ☐ Bloating
- ☐ Bloody bowel movements
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gallbladder disease
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis history
- ☐ Indigestion
- ☐ Jaundice (yellow eyes)
- ☐ Lactose intolerance
- ☐ Liver disease
- ☐ Loss of bowel control
- ☐ Nausea
- ☐ Pain with swallowing
- ☐ Poor appetite
- ☐ Trouble swallowing
- ☐ Ulcer disease
- ☐ Using laxatives
- ☐ Vomiting

⇨ Genitourinary
- ☐ Blood in urine
- ☐ Decreased sex drive
- ☐ Difficulty achieving orgasm
- ☐ Frequent urination
- ☐ Increased sex drive
- ☐ Loss of bladder control
- ☐ Painful intercourse
- ☐ Sexual arousal problems
- ☐ Trouble urinating

⇨ Musculoskeletal
- ☐ Arthritis
- ☐ Back Pain
- ☐ Breast mass/discharge
- ☐ Face badly flushed
- ☐ Itching
- ☐ Joint stiffness
- ☐ Muscle pain
- ☐ Skin rash
- ☐ Sweating often
- ☐ Swollen joints

⇨ Neurological
- ☐ Cluster headaches
- ☐ Migraine headaches
- ☐ Numbness or tingling
- ☐ Part of body paralyzed
- ☐ Seizure
- ☐ Severe headaches

⇨ Endocrine
- ☐ History of goiter
- ☐ Problems with calcium
- ☐ Problems with glands

⇨ Hematologic/Lymphatic
- ☐ Bleed easily
- ☐ Bruise easily
- ☐ History of anemia
- ☐ History of cancer
- ☐ History of tumor
- ☐ Swollen lymph glands

⇨ Allergic/Hematologic
- ☐ Drug allergies
- ☐ Food allergies
- ☐ Hay fever
- ☐ Hives

Psychiatric Diagnoses

Please check **all** past and present diagnoses.

- ☐ ADHD/ADD
- ☐ Agoraphobia
- ☐ Alcohol Abuse or Dependence
- ☐ Anorexia
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Bulimia
- ☐ Depression
- ☐ Eating Disorder
- ☐ Generalized Anxiety Disorder
- ☐ Learning Disorder
- ☐ Mental Retardation
- ☐ Nervous Breakdown
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Panic Disorder
- ☐ Personality Disorder
- ☐ Posttraumatic Stress Disorder
- ☐ Psychosis
- ☐ Schizophrenia
- ☐ Substance Abuse or Dependence
- ☐ Other: _____

Trauma Information

Please check all the following events you have experienced.

- ☐ Abduction
- ☐ Abandonment
- ☐ Assault
- ☐ Burglary
- ☐ Combat
- ☐ Domestic violence
- ☐ Kidnapping
- ☐ Natural disaster
- ☐ Physical abuse
- ☐ Rape
- ☐ Robbery
- ☐ Sexual abuse
- ☐ Sexual assault
- ☐ Witnessed killing
- ☐ Other: _____

Current Experiences

Please check **all** of the following experiences you **are having** or **have had** in the last **six months**.

⇨

- ☐ Excessive worry
- ☐ Excessive anxiety
- ☐ Very nervous
- ☐ Muscle tension
- ☐ Sleep disturbance

⇨

- ☐ Pounding heart
- ☐ Accelerated heart rate
- ☐ Shortness of breath
- ☐ Nausea or upset stomach
- ☐ Fear of losing control or of "going crazy"
- ☐ Fear of dying
- ☐ Numbness or tingling in lips/fingertips

⇨

- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Phobias/Fears
- ☐ Rituals

⇨

- ☐ Nightmares
- ☐ Flashbacks
- ☐ Scare easily
- ☐ Always watchful/aware
- ☐ Startle easily

⇨

- ☐ Elevated mood
- ☐ Expansive mood
- ☐ Irritable mood
- ☐ Decreased need for sleep
- ☐ More talkative than usual
- ☐ Racing thoughts
- ☐ Increase in activity
- ☐ Excessive spending

⇨

- ☐ Hearing voices
- ☐ Seeing visions
- ☐ Odd beliefs

⇨

- ☐ Depressed mood
- ☐ Irritable mood
- ☐ Fighting and arguing more
- ☐ Increased sadness
- ☐ Frequent crying
- ☐ Loss of interest in activities
- ☐ Loss of pleasure in activities
- ☐ Weight loss/gain
- ☐ Insomnia
- ☐ Hypersomnia
- ☐ Trouble concentrating
- ☐ Increased indecision
- ☐ Drinking more
- ☐ Smoking more
- ☐ Eating more
- ☐ Eating less
- ☐ Change in sex drive
- ☐ Change in sexual satisfaction