

Yes	No	
		<b>SKIN/ INTEGUMENTARY COMMENTS</b>
<input type="checkbox"/>	<input type="checkbox"/>	rashes _____
<input type="checkbox"/>	<input type="checkbox"/>	boils _____
<input type="checkbox"/>	<input type="checkbox"/>	itching _____
<input type="checkbox"/>	<input type="checkbox"/>	hives _____
		<b>HEAD / NECK / EYES</b>
<input type="checkbox"/>	<input type="checkbox"/>	frequent headaches _____
<input type="checkbox"/>	<input type="checkbox"/>	blurred vision _____
<input type="checkbox"/>	<input type="checkbox"/>	double vision _____
<input type="checkbox"/>	<input type="checkbox"/>	loss of vision _____
<input type="checkbox"/>	<input type="checkbox"/>	pain in eyes _____
<input type="checkbox"/>	<input type="checkbox"/>	neck pain _____
<input type="checkbox"/>	<input type="checkbox"/>	neck bumps _____
		<b>EARS</b>
<input type="checkbox"/>	<input type="checkbox"/>	dizziness _____
<input type="checkbox"/>	<input type="checkbox"/>	light-headed _____
<input type="checkbox"/>	<input type="checkbox"/>	earaches _____
<input type="checkbox"/>	<input type="checkbox"/>	discharge from ear _____
		<b>NOSE / THROAT</b>
<input type="checkbox"/>	<input type="checkbox"/>	frequent nosebleed _____
<input type="checkbox"/>	<input type="checkbox"/>	frequent head cold _____
<input type="checkbox"/>	<input type="checkbox"/>	sore throat _____
<input type="checkbox"/>	<input type="checkbox"/>	sinus problems _____
<input type="checkbox"/>	<input type="checkbox"/>	hoarseness _____
<input type="checkbox"/>	<input type="checkbox"/>	taste difficulty _____
<input type="checkbox"/>	<input type="checkbox"/>	smell difficulty _____
<input type="checkbox"/>	<input type="checkbox"/>	swallowing difficulty _____
<input type="checkbox"/>	<input type="checkbox"/>	problems with teeth _____
		<b>RESPIRATORY</b>
<input type="checkbox"/>	<input type="checkbox"/>	coughing up blood _____
<input type="checkbox"/>	<input type="checkbox"/>	wheezing _____
<input type="checkbox"/>	<input type="checkbox"/>	asthma _____
<input type="checkbox"/>	<input type="checkbox"/>	hay fever _____
<input type="checkbox"/>	<input type="checkbox"/>	bronchitis _____
<input type="checkbox"/>	<input type="checkbox"/>	pneumonia _____
<input type="checkbox"/>	<input type="checkbox"/>	chronic cough _____
		<b>METABOLIC / ENDOCRINE</b>
<input type="checkbox"/>	<input type="checkbox"/>	thirst (excessive) _____
<input type="checkbox"/>	<input type="checkbox"/>	urinary (excessive) _____
<input type="checkbox"/>	<input type="checkbox"/>	diabetes _____
<input type="checkbox"/>	<input type="checkbox"/>	thyroid low _____
<input type="checkbox"/>	<input type="checkbox"/>	thyroid high _____
<input type="checkbox"/>	<input type="checkbox"/>	cancer _____
<input type="checkbox"/>	<input type="checkbox"/>	chills _____
<input type="checkbox"/>	<input type="checkbox"/>	fever _____
<input type="checkbox"/>	<input type="checkbox"/>	night sweats _____
		<b>NEUROLOGIC</b>
<input type="checkbox"/>	<input type="checkbox"/>	fainting spells _____
<input type="checkbox"/>	<input type="checkbox"/>	blackouts _____
<input type="checkbox"/>	<input type="checkbox"/>	convulsions _____
<input type="checkbox"/>	<input type="checkbox"/>	tremors/ shaking _____
<input type="checkbox"/>	<input type="checkbox"/>	poor coordination _____
<input type="checkbox"/>	<input type="checkbox"/>	loss of strength _____

Yes	No	
		<b>CARDIOVASCULAR</b>
<input type="checkbox"/>	<input checked="" type="checkbox"/>	chest pains _____
<input type="checkbox"/>	<input type="checkbox"/>	high blood pressure _____
<input type="checkbox"/>	<input type="checkbox"/>	breath shortness _____
<input type="checkbox"/>	<input type="checkbox"/>	feet swelling _____
<input type="checkbox"/>	<input type="checkbox"/>	ankles swelling _____
<input type="checkbox"/>	<input type="checkbox"/>	circulation poor _____
<input type="checkbox"/>	<input type="checkbox"/>	blood clot _____
<input type="checkbox"/>	<input type="checkbox"/>	bleeding _____
<input type="checkbox"/>	<input type="checkbox"/>	irregular heart beat _____
<input type="checkbox"/>	<input type="checkbox"/>	thumping in heart _____
<input type="checkbox"/>	<input type="checkbox"/>	tightness in chest _____
		<b>GASTROINTESTINAL</b>
<input type="checkbox"/>	<input type="checkbox"/>	heartburn _____
<input type="checkbox"/>	<input type="checkbox"/>	indigestion _____
<input type="checkbox"/>	<input type="checkbox"/>	loss of appetite _____
<input type="checkbox"/>	<input type="checkbox"/>	recent weight gain _____
<input type="checkbox"/>	<input type="checkbox"/>	recent weight loss _____
<input type="checkbox"/>	<input type="checkbox"/>	stomach ulcer _____
<input type="checkbox"/>	<input type="checkbox"/>	nausea / vomiting _____
<input type="checkbox"/>	<input type="checkbox"/>	frequent constipation _____
<input type="checkbox"/>	<input type="checkbox"/>	frequent diarrhea _____
<input type="checkbox"/>	<input type="checkbox"/>	hemorrhoids / piles _____
<input type="checkbox"/>	<input type="checkbox"/>	painful bowel movements _____
<input type="checkbox"/>	<input type="checkbox"/>	chronic bloating _____
<input type="checkbox"/>	<input type="checkbox"/>	gas / belching _____
<input type="checkbox"/>	<input type="checkbox"/>	hepatitis _____
<input type="checkbox"/>	<input type="checkbox"/>	colitis _____
<input type="checkbox"/>	<input type="checkbox"/>	gallstones _____
<input type="checkbox"/>	<input type="checkbox"/>	diverticulitis _____
<input type="checkbox"/>	<input type="checkbox"/>	vomiting of blood _____
<input type="checkbox"/>	<input type="checkbox"/>	blood in stool _____
<input type="checkbox"/>	<input type="checkbox"/>	jaundice _____
		<b>URINARY</b>
<input type="checkbox"/>	<input type="checkbox"/>	urinary infections _____
<input type="checkbox"/>	<input type="checkbox"/>	blood in urine _____
<input type="checkbox"/>	<input type="checkbox"/>	inability to pass urine _____
<input type="checkbox"/>	<input type="checkbox"/>	urinating difficulty _____
<input type="checkbox"/>	<input type="checkbox"/>	kidney stones _____
<input type="checkbox"/>	<input type="checkbox"/>	inability to control urine _____
		<b>MUSCULOSKELETAL</b>
<input type="checkbox"/>	<input type="checkbox"/>	arthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	swollen joints _____
<input type="checkbox"/>	<input type="checkbox"/>	muscular pain _____
<input type="checkbox"/>	<input type="checkbox"/>	joint pain _____
<input type="checkbox"/>	<input type="checkbox"/>	chronic back pain _____
<input type="checkbox"/>	<input type="checkbox"/>	shoulder pain _____
<input type="checkbox"/>	<input type="checkbox"/>	morning stiffness _____
<input type="checkbox"/>	<input type="checkbox"/>	trigger points _____
		<b>MEN ONLY</b>
<input type="checkbox"/>	<input type="checkbox"/>	hernia _____
<input type="checkbox"/>	<input type="checkbox"/>	prostate trouble _____
<input type="checkbox"/>	<input type="checkbox"/>	urethral trouble _____

Yes No

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HEMATOLOGIC

- anemia
- bruising / bleeding
- past transfusion

COMMENTS

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ALLERGIC

- foods
- drugs
- molds
- dust
- pollen

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PSYCHIATRIC

- nervous
- insomnia
- nightmares
- depression
- mood

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Yes No

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CONSTITUTIONAL

- fever
- weight loss
- weakness
- fatigue

COMMENTS

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WOMEN ONLY

- irregular periods
- severe menstrual cramps
- vaginal infections

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