***Health History Questionnaire***

***Energetic Health Acupuncture & Oriental Medicine***

***230 N. 1680 E., Ste E2 ~ St. George, UT 84790***

***435-359-1479***

***Information for your Acupuncturist***

Important: Please complete this document as thoroughly as possible. Some of the questions that follow may seem unrelated to your condition, but they may play a major role in diagnosis and treatment.

***All information is strictly confidential***

**I. General Patient Information**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian (if under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: [ ] M [ ] F Height: \_\_\_\_’\_\_\_\_” Weight: \_\_\_\_\_\_\_\_lbs.

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell/Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications (Prescription & Over-the-counter): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major Complaint(s), in order of significance to you:

 Severe Moderate Slight Date of onset

1.     \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.    \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.    \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4.    \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5.    \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6.    \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7.    \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Please fill in the age and health information for family members. Place a checkmark where they have an applicable history.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Father | Mother | Brothers | Sisters | Child | Spouse |
| Health (G=good; P=poor) |  |  |  |  |  |  |
| Age, if living |  |  |  |  |  |  |
| If deceased, age of death |  |  |  |  |  |  |
| Cause of death |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |
| Heart Disease/ High Blood Pressure |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |
| Epilepsy |  |  |  |  |  |  |
| Mental Illness |  |  |  |  |  |  |
| Asthma, hay fever, hives |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |
| Other:  |  |  |  |  |  |  |

**Supplements (if any vitamins, herbs, minerals, etc): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Allergies:**

**Are you hypersensitive or allergic to:**

Any drugs? Yes  No Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any foods?  Yes  No Please list:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Symptom Profile**

For the following, please check **YES** for a condition you have **currently** and check **PAST** for a condition you’ve had in the past, noting the date in the space provided.

**Skin disorders:**

**Currently have? YES PAST WHEN?**

Acne, Boils   \_\_\_\_\_\_\_\_\_\_\_\_\_

Acute Hair Loss   \_\_\_\_\_\_\_\_\_\_\_\_\_

Color Change   \_\_\_\_\_\_\_\_\_\_\_\_\_

Eczema, Hives   \_\_\_\_\_\_\_\_\_\_\_\_\_

Itching   \_\_\_\_\_\_\_\_\_\_\_\_\_

Nail Fungus   \_\_\_\_\_\_\_\_\_\_\_\_\_

Dry Skin   \_\_\_\_\_\_\_\_\_\_\_\_\_

Rash   \_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Respiratory System Disorders:**

**Currently have? YES PAST WHEN?**

Bronchitis   \_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Asthma   \_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic Cough   \_\_\_\_\_\_\_\_\_\_\_\_\_

Emphysema   \_\_\_\_\_\_\_\_\_\_\_\_\_

Frequent Colds   \_\_\_\_\_\_\_\_\_\_\_\_\_

Pain in Breathing   \_\_\_\_\_\_\_\_\_\_\_\_\_

Pleurisy   \_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia   \_\_\_\_\_\_\_\_\_\_\_\_\_

Shortness of Breath   \_\_\_\_\_\_\_\_\_\_\_\_\_

Sinus Congestion   \_\_\_\_\_\_\_\_\_\_\_\_\_

Spitting up Blood   \_\_\_\_\_\_\_\_\_\_\_\_\_

Temporary Cough   \_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis   \_\_\_\_\_\_\_\_\_\_\_\_\_

Nasal drainage   \_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Emotional or Mental Illness:**

**Currently have? YES PAST WHEN?**

Anxiety   \_\_\_\_\_\_\_\_\_\_\_\_\_

Depression   \_\_\_\_\_\_\_\_\_\_\_\_\_

Considered or Attempted Suicide

   \_\_\_\_\_\_\_\_\_\_\_\_\_

Irritability   \_\_\_\_\_\_\_\_\_\_\_\_\_

Mood Swings   \_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Head, Ear, Eyes, Nose, Throat:**

**Currently have: YES PAST WHEN?**

Headaches   \_\_\_\_\_\_\_\_\_\_\_\_\_

Migraines   \_\_\_\_\_\_\_\_\_\_\_\_\_

Head Injury   \_\_\_\_\_\_\_\_\_\_\_\_\_

Hay Fever   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Ears: YES PAST WHEN?**

Earaches   \_\_\_\_\_\_\_\_\_\_\_\_\_

Ringing in Ears   \_\_\_\_\_\_\_\_\_\_\_\_\_

Impaired Hearing   \_\_\_\_\_\_\_\_\_\_\_\_\_

Dizziness   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Eyes:**

Cataracts   \_\_\_\_\_\_\_\_\_\_\_\_\_

Color Blindness   \_\_\_\_\_\_\_\_\_\_\_\_\_

Contacts or Glasses   \_\_\_\_\_\_\_\_\_\_\_\_\_

Double Vision   \_\_\_\_\_\_\_\_\_\_\_\_\_

Eye Pain or Strain   \_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma   \_\_\_\_\_\_\_\_\_\_\_\_\_

Impaired Vision   \_\_\_\_\_\_\_\_\_\_\_\_\_

Tearing or Dryness   \_\_\_\_\_\_\_\_\_\_\_\_\_

Spots in Front of Eyes   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Nose:**

Nose Bleeds   \_\_\_\_\_\_\_\_\_\_\_\_\_

Loss of Smell   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Mouth:**

Bleeding Gums   \_\_\_\_\_\_\_\_\_\_\_\_\_

Dental Cavities   \_\_\_\_\_\_\_\_\_\_\_\_\_

Dry Mouth   \_\_\_\_\_\_\_\_\_\_\_\_\_

Oral Sores   \_\_\_\_\_\_\_\_\_\_\_\_\_

Oral Thrush   \_\_\_\_\_\_\_\_\_\_\_\_\_

Teeth Grinding   \_\_\_\_\_\_\_\_\_\_\_\_\_

Jaw Problems, TMJ   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Throat:**

**Currently have? YES PAST WHEN?**

Goiter   \_\_\_\_\_\_\_\_\_\_\_\_\_

Hoarseness   \_\_\_\_\_\_\_\_\_\_\_\_\_

Swollen Glands   \_\_\_\_\_\_\_\_\_\_\_\_\_

Trouble Swallowing   \_\_\_\_\_\_\_\_\_\_\_\_\_

Neck Pain/Stiffness   \_\_\_\_\_\_\_\_\_\_\_\_\_

Frequent Sore Throat   \_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Digestive Disorders:**

**Currently have? YES PAST WHEN?**

Nausea   \_\_\_\_\_\_\_\_\_\_\_\_\_

Vomiting   \_\_\_\_\_\_\_\_\_\_\_\_\_

Loss of Appetite   \_\_\_\_\_\_\_\_\_\_\_\_\_

Ulcer   \_\_\_\_\_\_\_\_\_\_\_\_\_

Heartburn   \_\_\_\_\_\_\_\_\_\_\_\_\_

Gas or bloating   \_\_\_\_\_\_\_\_\_\_\_\_\_

Internal Cramping   \_\_\_\_\_\_\_\_\_\_\_\_\_

Constipation   \_\_\_\_\_\_\_\_\_\_\_\_\_

Diarrhea   \_\_\_\_\_\_\_\_\_\_\_\_\_

Loose Stool   \_\_\_\_\_\_\_\_\_\_\_\_\_

Hemorrhoids   \_\_\_\_\_\_\_\_\_\_\_\_\_

Bowel Movement Frequency? \_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a change? \_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular Disorders:**

**Currently have? YES PAST WHEN?**

Heart Disease   \_\_\_\_\_\_\_\_\_\_\_\_\_

Endocarditis   \_\_\_\_\_\_\_\_\_\_\_\_\_

Chest Pain   \_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Murmur   \_\_\_\_\_\_\_\_\_\_\_\_\_

Palpitations or fluttering   \_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure   \_\_\_\_\_\_\_\_\_\_\_\_\_

Low Blood Pressure   \_\_\_\_\_\_\_\_\_\_\_\_\_

Phlebitis   \_\_\_\_\_\_\_\_\_\_\_\_\_

Blood Clots   \_\_\_\_\_\_\_\_\_\_\_\_\_

Ankle Swelling   \_\_\_\_\_\_\_\_\_\_\_\_\_

Fainting   \_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Urinary Tract Disorders:**

**Currently have? YES PAST WHEN?**

Frequent infection   \_\_\_\_\_\_\_\_\_\_\_\_\_

Frequent Night Urination   \_\_\_\_\_\_\_\_\_\_\_\_\_

Inability to hold urine   \_\_\_\_\_\_\_\_\_\_\_\_\_

Burning or pain during urination

   \_\_\_\_\_\_\_\_\_\_\_\_\_

Increased frequency   \_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney stones   \_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Musculoskeletal Disorders:**

**Currently have? YES PAST WHEN?**

Weakness   \_\_\_\_\_\_\_\_\_\_\_\_\_

Muscle Spasms or cramps

   \_\_\_\_\_\_\_\_\_\_\_\_\_

Joint pain, swelling, or stiffness

   \_\_\_\_\_\_\_\_\_\_\_\_\_

Sciatica   \_\_\_\_\_\_\_\_\_\_\_\_\_

Fibromyalgia   \_\_\_\_\_\_\_\_\_\_\_\_\_

Broken bones   \_\_\_\_\_\_\_\_\_\_\_\_\_

Any other pain   \_\_\_\_\_\_\_\_\_\_\_\_\_

Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Miscellaneous:**

**Currently have? YES PAST WHEN?**

Easy bleeding or bruising   \_\_\_\_\_\_\_\_\_\_\_\_\_

Varicose veins   \_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia   \_\_\_\_\_\_\_\_\_\_\_\_\_

Slow wound healing   \_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic infections   \_\_\_\_\_\_\_\_\_\_\_\_\_

Day sweats   \_\_\_\_\_\_\_\_\_\_\_\_\_

Night sweats   \_\_\_\_\_\_\_\_\_\_\_\_\_

Cold hands or feet   \_\_\_\_\_\_\_\_\_\_\_\_\_

Heat or cold intolerance   \_\_\_\_\_\_\_\_\_\_\_\_\_

Fatigue   \_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic fatigue syndrome   \_\_\_\_\_\_\_\_\_\_\_\_\_

Hypoglycemia   \_\_\_\_\_\_\_\_\_\_\_\_\_

Hyperthyroid   \_\_\_\_\_\_\_\_\_\_\_\_\_

Excessive Thirst   \_\_\_\_\_\_\_\_\_\_\_\_\_

Excessive hunger   \_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes   \_\_\_\_\_\_\_\_\_\_\_\_\_

Gallbladder disease   \_\_\_\_\_\_\_\_\_\_\_\_\_

Liver disease   \_\_\_\_\_\_\_\_\_\_\_\_\_

Jaundice   \_\_\_\_\_\_\_\_\_\_\_\_\_

Hepatitis   \_\_\_\_\_\_\_\_\_\_\_\_\_

Type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle Habits:**

**Do you…**

Exercise?  No Yes

 What kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Take vacations?  No Yes

 How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep habits:**

Do you…

Sleep well?  No Yes

Awaken rested  No Yes

Average 6-8 hrs sleep  No Yes

Spend time outside  No Yes

What time of day is your energy at its best?\_\_\_\_\_\_\_\_

**Tobacco, food and drink habits:**

**Do you…**

Use tobacco  No Yes

 How much/how often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoked previously?  No Yes

 How long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How many packs a day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ever been treated for drug dependence?  No Yes

Drink Alcohol?  No Yes

 How much/often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drink caffeinated beverages?  No Yes

 How much/often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eat out?  No Yes

 Times per week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many meals to you eat per day?\_\_\_\_\_\_\_

Go on diets often?  No Yes

Typical food intake:

Breakfast\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which selection most closely describes your diet? (You may check more than one item)

 Vegan  Raw Foods  Vegetarian Mostly Vegetarian  Low fat  Low carb  Allergy conscious

 Fast food/restaurants  Ethnic  Typical American

Which of these selections do you take daily (3 checks), several times a week (2 checks), once a week (1 check):

Sugar\_\_\_\_\_ Sugar substitutes\_\_\_\_\_ Coffee\_\_\_\_\_ Tobacco\_\_\_\_\_ Red Meat\_\_\_\_\_ Alcohol\_\_\_\_\_ Diet drinks\_\_\_\_\_

Any history of psychological, physical or sexual abuse?  No Yes

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR MEN ONLY:**

Do you now, or have you ever had…?

Testicular masses  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Testicular pain  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prostate Disease  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Impotence  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Premature ejaculation  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hernias  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condyloma  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Syphilis  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genital, oral or rectal herpes  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gonorrhea  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR WOMEN ONLY:**

Do you now, or have you ever had…?

Breast lumps  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nipple discharge  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Breast pain or tenderness  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abnormal PAP smear  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cervical displasia  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vaginal discharge  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gonorrhea  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Syphilis  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genital, oral or rectal herpes  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condyloma  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fibroids  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ovarian cysts  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual difficulties  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you on birth control?  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of live births \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of miscarriages \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of abortions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age at first menses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of cycle in days \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration of period in days\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PMS symptoms  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Painful menses  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clotting during menses  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bleeding between periods  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Menopausal symptoms  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No Yes When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_