

Name (Last, First, Middle)

Date:

Please Check All Symptoms You Currently Have or Have Had Within the Past Year:

<p>General</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chills <input type="checkbox"/> Low Energy <input type="checkbox"/> Dizziness <input type="checkbox"/> Allergies <input type="checkbox"/> Fatigue <input type="checkbox"/> Fevers <input type="checkbox"/> Excess Thirst <input type="checkbox"/> Insomnia <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweat Spontaneously <input type="checkbox"/> Night Sweating <input type="checkbox"/> Lack of Sweating <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Aversion to Heat <input type="checkbox"/> Aversion to Cold <p>Head and Neck</p> <ul style="list-style-type: none"> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Heaviness in the Head <input type="checkbox"/> Headache <input type="checkbox"/> Phlegm in Throat <input type="checkbox"/> Cataract <input type="checkbox"/> Double Vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear Discharge <input type="checkbox"/> Eye Pain/Strain <input type="checkbox"/> Nasal Obstruction <input type="checkbox"/> Nasal Discharge <input type="checkbox"/> Loss of Sense of Smell <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Recurrent Sore Throat <input type="checkbox"/> Red/Inflamed Eye <input type="checkbox"/> Ringing in Ear <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Sores on Lips <input type="checkbox"/> Sores on Tongue <input type="checkbox"/> Taste Change <input type="checkbox"/> Teeth Problems <input type="checkbox"/> Vision – see halos <p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Hay Fever <input type="checkbox"/> Persistent Cough <input type="checkbox"/> Coughing Blood <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Recurrent Bronchitis <input type="checkbox"/> Phlegm Production <input type="checkbox"/> Difficulty Inhaling <input type="checkbox"/> Difficulty Exhaling 	<p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Swelling of Ankles <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Distention in Chest <p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Bloating <input type="checkbox"/> Belching <input type="checkbox"/> Gas <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea/Loose Stools <input type="checkbox"/> Bloody Stools <input type="checkbox"/> Black Stools <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Stomachache <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting Blood <p>Diet</p> <ul style="list-style-type: none"> <input type="checkbox"/> Vegetarian <input type="checkbox"/> Healthy Diet <input type="checkbox"/> Eat Much Fried Foods <input type="checkbox"/> Eat Much Meat <input type="checkbox"/> Smoke Cigarettes <input type="checkbox"/> Drink Alcohol <input type="checkbox"/> Drink Coffee <input type="checkbox"/> Eat a Lot of Sweets <p>Emotional</p> <ul style="list-style-type: none"> <input type="checkbox"/> Insomnia <input type="checkbox"/> Irritability <input type="checkbox"/> Often Feel Angry <input type="checkbox"/> Troubling Dreams <input type="checkbox"/> Cry Uncontrollably <input type="checkbox"/> Feel Sad A Lot <input type="checkbox"/> Forgetful <input type="checkbox"/> Mind Not Clear <input type="checkbox"/> Anxiety <input type="checkbox"/> Much Fear <input type="checkbox"/> Unrestrained Joy <input type="checkbox"/> Terrors <input type="checkbox"/> Difficulty Expressing Emotion 	<p>Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dilute Urine <input type="checkbox"/> Dark Urine <input type="checkbox"/> Blood In Urine <input type="checkbox"/> Cloudy Urine <input type="checkbox"/> Burning Urination <input type="checkbox"/> Scanty Urine <input type="checkbox"/> Profuse Urine <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Poor Bladder Control <input type="checkbox"/> Urgency to Urinate <p>Musculoskeletal</p> <p>Pain, weakness, numbness in:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arms <input type="checkbox"/> Feet <input type="checkbox"/> Hands <input type="checkbox"/> Joints <input type="checkbox"/> Legs <input type="checkbox"/> Hips <input type="checkbox"/> Neck <input type="checkbox"/> Shoulders <input type="checkbox"/> Pain All Over <input type="checkbox"/> Cold Limbs <input type="checkbox"/> Knee Problems <input type="checkbox"/> Low Back Pain <input type="checkbox"/> All Over Weakness <input type="checkbox"/> Lack of Strength <input type="checkbox"/> Broken Bones <p>Skin</p> <ul style="list-style-type: none"> <input type="checkbox"/> Thick Skin <input type="checkbox"/> Thin Skin <input type="checkbox"/> Broken Blood Vessels <input type="checkbox"/> Blood Not Clotting <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Discoloration <input type="checkbox"/> Dark Circles Around Eyes <input type="checkbox"/> Bags Under Eyes <input type="checkbox"/> Lumps in Groin <input type="checkbox"/> Lumps Underarm <input type="checkbox"/> Dry Skin <input type="checkbox"/> Acne <input type="checkbox"/> Brittle Nails <input type="checkbox"/> Premature Gray Hair <input type="checkbox"/> Dry, Brittle Hair <input type="checkbox"/> Hair Falling Out <p>Weight</p> <ul style="list-style-type: none"> <input type="checkbox"/> Underweight <input type="checkbox"/> Normal for Height <input type="checkbox"/> Overweight <input type="checkbox"/> Very Overweight 	<p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fainting <input type="checkbox"/> Convulsing <input type="checkbox"/> Handwriting Change <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures <input type="checkbox"/> Tremor <input type="checkbox"/> Recent Clumsiness <input type="checkbox"/> Drowsiness <input type="checkbox"/> Vertigo <p>Women Only</p> <ul style="list-style-type: none"> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleed Between Periods <input type="checkbox"/> Irregular Periods <input type="checkbox"/> Heavy Periods <input type="checkbox"/> < 25 day cycle <input type="checkbox"/> > 35 day cycle <input type="checkbox"/> Endometriosis <input type="checkbox"/> Painful Periods <input type="checkbox"/> Premenstrual Tension <input type="checkbox"/> Breast Lumps <input type="checkbox"/> Contraceptives <input type="checkbox"/> Sores on Genitalia <input type="checkbox"/> Low Sexual Energy <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Menopausal <input type="checkbox"/> Uterine Prolapse <input type="checkbox"/> Facial Hair <input type="checkbox"/> Loss of Head Hair <input type="checkbox"/> May Be Pregnant <p>Significant Illness</p> <ul style="list-style-type: none"> <input type="checkbox"/> Arthritis <input type="checkbox"/> AIDS <input type="checkbox"/> Auto Immune Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Connective Tissue Disease <input type="checkbox"/> Gallstones <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hypertension <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Venereal Disease <p>Lifestyle</p> <ul style="list-style-type: none"> <input type="checkbox"/> Exercise Regularly <input type="checkbox"/> Exercise Excessively <input type="checkbox"/> Take Steroids <input type="checkbox"/> Take Melatonin <input type="checkbox"/> Use Drugs
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