

For Women

Age of 1st Period (menarche) _____ Are you Pregnant? Yes No # of Pregnancies _____

Age of last period (menopause) _____ # of live births _____ # of abortions _____ # of miscarriages _____

Number of days between periods _____ Date of last gynecologic exam _____ Pap smear _____

Number of days of flow _____ Mammogram _____ Bone density scan _____

Color of flow _____ Results _____

Clots? Yes No Color _____

Average number of pads you use per day: 1st day _____ 2nd day _____ 3rd day _____ 4th day _____ + days _____

Have you been diagnosed with: Fibroids Fibrocystic Breasts Endometriosis Ovarian Cysts PID Other _____

Location of pain: Lower abdomen Lower back Thighs Other _____

Location of pain: *(Please indicate before, during, or after menses)* _____

Cramping _____ Stabbing _____ Burning _____ Aching _____ Dull _____ Bloating _____ Consistent _____ Intermittent _____ Bearing down sensation _____	Other symptoms related to menses <input type="checkbox"/> Discharge <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Headache <input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Ravenous appetite <input type="checkbox"/> Swollen breasts <input type="checkbox"/> Mood swings <input type="checkbox"/> Diarrhea <input type="checkbox"/> Poor appetite <input type="checkbox"/> Hot flashes <input type="checkbox"/> Night sweats <input type="checkbox"/> Increased libido <input type="checkbox"/> decreased libido <input type="checkbox"/> Insomnia
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For Men

Date of last prostate check up _____ PSA results _____ Manual prostate exam results _____

Lab results _____

Frequency of urination: daytime _____ nighttime: _____ Color of urine clear murky odor: _____

Symptoms related to prostate

<input type="checkbox"/> Prostate problems	<input type="checkbox"/> Delayed stream	<input type="checkbox"/> Dribbling	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Retention of urine
<input type="checkbox"/> Rectal dysfunction	<input type="checkbox"/> Increased libido	<input type="checkbox"/> Decreased libido	<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/> Impotence
<input type="checkbox"/> Back pain	<input type="checkbox"/> Groin pain	<input type="checkbox"/> Testicular pain	<input type="checkbox"/> Other _____	

Symptom Survey (For Everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:

No mark () = never experience

check mark (✓) = sometimes

plus sign (+) = frequently experience

___ lack of appetite	___ laughing for no apparent reason	___ eye problems	___ hair loss
___ excessive appetite	___ abdominal pain	___ jaundice (yellowish eyes or skin)	___ urinary problems
___ loose stool or diarrhea	___ chest pain	___ gall stones	___ fatigue
___ digestive problems, indigestion	___ sciatic pain	___ difficulty digesting oily foods	___ edema
___ vomiting	___ headaches	___ light colored stool	___ blood in stool
___ belching, burping	___ pain or coldness in the genital area	___ soft or brittle nails	___ black tarry stool
___ heartburn/reflux	___ cough	___ easily angered or agitated	___ easily bruised
___ feeling the retention of food in the stomach	___ shortness of breathe	___ difficulty in making plans or decisions	___ difficult to stop bleeding
___ tendency to become obsessive in work, relationships...	___ decreased sense of smell	___ spasms or twitching of muscles	___ asthma
___ insomnia, difficulty sleeping	___ nasal problems	___ low back pain	___ tendency to catch colds easily
___ heart palpitations	___ skin problems	___ knee problems	___ intolerance to weather changes
___ cold hands / feet	___ claustrophobia	___ hearing impairment	___ allergies
___ nightmares	___ bronchitis	___ ear ringing	___ hay fever
___ mentally restless	___ colitis or diverticulitis	___ kidney stones	___ dizziness
___ angina pains	___ constipation	___ decreased sex drive	___ tendency to faint easily
	___ hemorrhoids		___ high cholesterol levels
	___ recent use of antibiotics		___ sudden weight loss