Anti-Aging & Regenerative Associates

851 Dunlawton Ave., Ste. 104, Port Orange, Fl. 32127 - P:386-366-7418 F:386-366-8807
Email: officeAARA@gmail.com

The following information provided is confidential and is for medical purposes only. It is important you fill it out to the best of your ability. Even if the question seems not to apply to your current condition please fill this form out completely as many things can be connected and will help us better serve you.

**Name:**_____ **Today's Date:**_____(mm/dd/yr)

**DOB:**_____ (mm/dd/yr) **Current age**:____ **Height**:____ **Weight**:_____ **Gender**: ☐ **male** ☐ **female**

**Address:**_____ **City:**_____ **State:**____ **Zip Code:**_____

**Home Phone:**_____ Permission to leave a 'medical' message? ☐ **Yes** ☐ **No**

**Cell Phone:**_____ Permission to leave a 'medical' message? ☐ **Yes** ☐ **No**

**Email for medical/healthcare correspondence:**_____

**Occupation:**_____ **Employer:**_____

**Emergency Contact Name:**_____ **Phone #:**_____

**Please Describe your current problem/complaint that brought you to our office:** List them in order of importance. For example #1 is most important, and #5 is least important. *(if your complaint is of pain please also use the diagram on the following page)*

**1.**_____

**2.**_____

**3.**_____

**4.**_____

**5.**_____

How long have you had the above condition/s? _____ Is it getting worse? ☐ yes ☐ no

Does it effect your (check appropriate box) ☐ work, ☐ sleep, ☐ other:_____

Initial cause of complaint: _____

**Major goals for your our first visit:** Let us know what you would like to accomplish on your first visit.

**1.**_____

**2.**_____

**3.**_____

**4.**_____

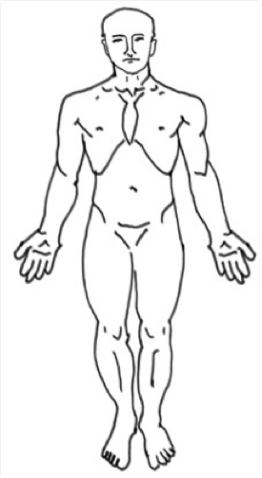
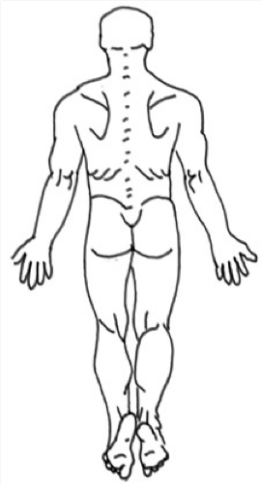
**Have you been treated for this condition in the past/present?** ☐ yes ☐ no; If YES, by whom?

_____

**Have you been diagnosed for this condition?** ☐ yes ☐ no; Diagnosis:_____

Is there anything else the Doctor should know about *you* or your *condition*?_____

**Please choose a number corresponding with your pain. 10 = worst pain of your life, 0 = no pain**
**Use the drop down boxes to indicate the location of your pain.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Deny | 0 | | | | | Deny | 0 |
| Deny | 0 | | | | | Deny | 0 |
| Deny | 0 | R |  | L |  | Deny | 0 |
| Deny | 0 | | | | | Deny | 0 |
| Deny | 0 | | | | | Deny | 0 |

## PAST HISTORY

| Have you… | Yes | No | If yes, explain briefly WITH approximate date/year |
|---|---|---|---|
| ... ever been hospitalized? | ☐ | ☐ | _____ |
| ... had any surgeries? | ☐ | ☐ | _____ |
| ... had any mental disorders? | ☐ | ☐ | _____ |
| ... had any broken bones? | ☐ | ☐ | _____ |
| ... had any strains or sprains? | ☐ | ☐ | _____ |

Have you ever been bitten by a *tick or spider* that you know of? ☐ **yes** ☐ **no** If yes, did you have a reaction such as a rash, fever, joint pain, etc. ☐ **yes** ☐ **no**

_____

Have you ever have mono or Epstein barr virus? ☐ **yes** ☐ **no**

Have you had any other infections? ☐ **yes** ☐ **no** :_____

Do you have any allergies to foods, medications or environment? _____

_____

## FAMILY HISTORY

- ☐ Cancer _____
- ☐ High blood pressure _____
- ☐ Anemia _____
- ☐ Diabetes _____
- ☐ High cholesterol _____
- ☐ Arteriosclerosis _____
- ☐ Emphysema _____
- ☐ Multiple sclerosis _____
- ☐ Epilepsy _____
- ☐ Osteoporosis _____
- ☐ Stroke _____
- ☐ Bleed easily _____
- ☐ Heart disease _____
- ☐ Thyroid disease _____
- ☐ Dementia/Alzheimer's/Parkinson's _____
- ☐ OTHER: _____

_____

_____

**HABITS and LIFESTYLE** ⦿(reset)

**Please choose any of the following you consume:** ◯ Tobacco ◯ Alcohol ◯ Drugs ◯ Coffee ◯ Soft drinks

Amount consumed _____ Frequency _____

Do you exercise regularly? If YES-what do you do? If NO what keeps you from exercise? _____

**DIET**-Do you Follow any particular diet regimen or restrictions?:_____

_____

**MOST RECENT VISIT TO A DOCTOR**: *When was the last time you consulted a doctor, and for what reason?*

**Date of last complete physical exam**: _____

**Date of most recent lab/blood tests:** _____

***WOMEN—date of last PAP smear***: _____results:_____

**Currently pregnant?** No

***Do you still have your monthly period?*** No

**Do you have any children?** No **How many?**_____ **Healthy?**_____

Name/s of your children:_____

**Is there anything else the Doctor should know or you would like to elaborate on?:**

_____

_____

_____

_____

**Current prescription medications** (e.g., Prozac, lipitor, etc), **non-prescription medications** (e.g., aspirin, Tylenol, ibuprofen) and/or **health supplements** (e.g., vitamins, minerals, herbs): *Please list the medications and/or supplements that you are currently taking. If you need more room please attached a sheet to this form.* ***Please also list any drug allergies****.*

| **NAME** *of medication or supplement—drugs, vitamins, herbs, minerals* | **DOSE** *in milligrams or grams (or number of capsules, tablets)* | **FREQUENCY***:* **Times per day/ week/ month** | **DURATION***: Been* **taking for how long?** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

REVIEW of SYSTEMS: Place a check mark in the most appropriate number for each attribute so we can better understand and discuss your current condition. Although this list is extensive it is important to fill out completely and as accurately as possible. If you mark "YES" to a question please provide additional info to the right.

| EMOTIONAL and SOCIAL HEALTH | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Depression, sadness | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Anger, irritability, anxiety | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Stressful situations | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Apathy, lack of interest or concern | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Isolation, few friends, distant family | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Problems with parents or family | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Problems with employer(s) or coworker(s) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Recent or current thought of suicide | ☐ NO | ☐ YES | | |
| Diagnosed mental condition such as bipolar, schizophrenia, or other condition | ☐ NO | ☐ YES | | |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| EYES | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Watery, red, or itchy eyes | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Dark circles under eyes | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Decrease or loss of vision; cataracts, or glaucoma | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Blurry vision | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Poor night vision, night blindness | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Pain in eye(s) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Pain near or behind eye(s) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Corrective lenses; glasses or contacts | ☐ NO | ☐ YES | | |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| EARS | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Earaches, pain in ear(s) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Ringing in ear(s) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Ear infections | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Decrease or loss of hearing | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| MOUTH, NOSE, and THROAT | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Swollen or tender mouth or gums | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Decreased sense of taste or smell | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Stuffy nose, nasal congestion | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sinus infections, sinus pain | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Nasal polyps | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Ulcers or sores in mouth or lips, oral herpes | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Bleeding gums | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| White coating on the tongue | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Dry mouth | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Bad breath | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sore throat | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Allergies, sneezing, runny nose | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Excessive mucus formation | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Drainage to back of throat | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Cough or wheeze | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Change in voice | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Hoarseness, loss of voice | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| GENERAL HEALTH | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Fatigue, lack of energy, lack of stamina | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Decrease or alter activities due to fatigue, lack of energy, or illness | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Insomnia, lack of sleep | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Excessive tiredness and increased need for sleep | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Tired after waking | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Pain at night | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Enlarged lymph nodes | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Frequent infections | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Undesired weight loss | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Undesired weight gain, difficulty losing weight | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Cold hands or feet | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Crave chocolate | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Cuts heal slowly and/or scar easily | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Compulsive/binge eating, increased appetite | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Decreased appetite | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sensitivity to fumes, chemicals, odors, or exhaust | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Hypoglycemia, low blood sugar | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Past testing or positive result for iron disorders | ☐ NO | ☐ YES | | |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| MUSCLES and JOINTS | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Pain, swelling, or limited motion in joint(s) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Pain, swelling, or weakness in muscle(s) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Cramps in muscles, grind teeth at night? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| HEAD and MIND | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Headaches | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Migraines | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Pressure inside head | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Faintness, loss of consciousness | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Dizziness | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Seizures, epilepsy | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Difficulty thinking or processing information, confusion | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Difficulty with concentration or maintaining attention | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Poor memory | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Difficulty speaking or talking, slurred speech | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Hyperactivity | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Learning difficulties, dyslexia | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Difficulty “finding words” | ☐ | ☐ | ☐ | ☐ |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

# Review of Systems Continued

| LUNGS and HEART | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Chest congestion, bronchitis | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Asthma | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Discomfort at high altitude | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Shortness of breath, difficulty breathing | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Irregular heartbeat | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Pain in left arm and/or left side of neck or face | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Swelling of upper or lower limbs | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Rapid or pounding heartbeat | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Muscle cramps with exertion | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Pain in chest | ☐ NO | ☐ YES | | |
| High blood pressure, high cholesterol, or high triglycerides | ☐ NO | ☐ YES | | |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| SKIN, HAIR, and NAILS | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Acne | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Eczema | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Psoriasis | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Flushing, hot flashes | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Dry skin | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Oily skin | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Itchy skin, hives | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Decrease in body or facial hair | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Decrease in head hair (not pattern baldness) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Increase in body or facial hair | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Excessive sweating | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Insufficient sweating when hot or active | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Area(s) of numbness | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Area(s) of tingling | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Area(s) of pain | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Change in skin color or pigmentation, vitiligo | ☐ NO | ☐ YES | | |
| Weak or ridged fingernails | ☐ NO | ☐ YES | | |
| White spots on fingernails | ☐ NO | ☐ YES | | |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| STOMACH and DIGESTIVE TRACT | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Heartburn, GERD, acid reflux | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Nausea | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Vomiting | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sense of fullness after meals | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sleepy after meals | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feel better if you don't eat | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Stomach pains and cramps | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Vitamins upset your stomach | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Crave carbohydrates (breads, pasta) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Wheat or grain sensitivity | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Dairy sensitivity | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Belching, bloating, gas one hour after eating | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sweat has a strong odor or general strong body odor | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Excessive gas | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Diarrhea | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Constipation | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Undigested food in stool | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Black, tarry colored stools | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Stools hard or difficult to pass | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Blood or mucus in stools | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Hemorrhoids | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Rectal itching | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| History of parasites | ☐ NO | ☐ YES | | |
| Food allergies | ☐ NO | ☐ YES | | |
| History of hepatitis | ☐ NO | ☐ YES | | |
| Loss of bowel control, incontinence | ☐ NO | ☐ YES | | |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| LIVER and GALLBLADDER | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Stomach upset by greasy foods | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sea, car, plane sickness | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Greasy or shiny stools | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Light or clay colored stools | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sensitive to chemicals (perfume, etc) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sensitive to tobacco smoke | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Chronic fatigue or fibromyalgia | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Artificial sweetener consumption | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Gallbladder removed | ☐ NO | ☐ YES | | |
| Easily hung over | ☐ NO | ☐ YES | | |
| Easily intoxicated | ☐ NO | ☐ YES | | |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| KIDNEYS and GENITALS | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Kidney stones | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Difficulty controlling urination, incontinence | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Frequent urination | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Pain or burning with urination | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Cloudy, bloody, or dark urine | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Urinary tract (kidney, bladder, urethra) infection(s) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sexually transmitted disease(s) | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Genital herpes | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Low sex drive, low libido | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Have you been tested for HIV? | ☐ NO | ☐ YES | ☐ Positive | ☐ Negative |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| ADRENAL and THYROID GLANDS | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Crave sweets | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Crave caffeine or sugar in the afternoon | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Crave salty foods | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Fatigue relieved by eating | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Shaky if meals are skipped | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Afternoon headaches | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Feel weird or jittery after caffeine | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Headache after exercising | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Become dizzy when standing | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Perspire easily | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Tendency to need sunglasses | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Tend to be a “night person” | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Difficulty falling asleep | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Trouble calming down | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Awaken a few hours after falling asleep | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Sensitivity/allergic to iodine | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Nervous, emotional, can’t work under pressure | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Flush easily | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Intolerant to heat or cold | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Morning headaches get better as day progresses | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Seasonal sadness | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| For WOMAN only- HORMONAL STATUS | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Irregular or missed menses | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Painful menses | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Pain between menses | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Painful, swollen, or fibrocystic breasts | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Excessive bleeding | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Heavy clotting | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Mood fluctuations that follow your cycle | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Hot flashes | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Night sweats | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Thinning skin | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Vaginal dryness, irritation, painful intercourse | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Yeast infections | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Uterine fibroids | ☐ NO | ☐ YES | | |
| Menopausal symptoms or concerns | ☐ NO | ☐ YES | | |
| Annual Pap smear, breast examination | ☐ NO | ☐ YES | | |
| Family history of breast, uterine, or ovarian cancer | ☐ NO | ☐ YES | | |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |

| For MEN only- HORMONAL STATUS | None - Very rare | Occasional - Mild | Intermittent - Moderate | Frequent - Severe |
|---|---|---|---|---|
| Pain or difficulty obtaining or maintaining erections | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Pain or difficulty with ejaculation | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Pain or mass in testicles | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Waking to urinate at night | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Difficult to stop and start urination | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| Prostate problems | ☐ NO | ☐ YES | | |
| Undescended testis, testis in abdomen or pelvis | ☐ NO | ☐ YES | | |
| Family history of prostate cancer | ☐ NO | ☐ YES | | |
| Men over 50: annual PSA test an prostate exam? | ☐ NO | ☐ YES | | |
| Other problem, concern, or question in this area | ☐ NO | ☐ YES | | |