Harmony Women's Health

General History Form

Name:___________________________________ Date:_______________

Information about your health

What problems or issues do you want addressed? *Check all that apply.*

- ❑ Abnormal uterine bleeding
- ❑ Acne
- ❑ Allergies
- ❑ Annual exam-Pap smear
- ❑ Anxiety
- ❑ Back pain
- ❑ Bladder problems
- ❑ Bowel problems
- ❑ Brain fog
- ❑ Cancer survivor
- ❑ Candida
- ❑ Carbohydrate cravings
- ❑ Chronic pelvic pain
- ❑ Constipation
- ❑ Contraception
- ❑ Depression
- ❑ Disease prevention
- ❑ Emotional problems
- ❑ Endometriosis
- ❑ Excess hair growth
- ❑ Fatigue/exhaustion
- ❑ Fertility enhancement
- ❑ Fevers
- ❑ Fibroids
- ❑ General health improvement
- ❑ Hair loss
- ❑ Headaches
- ❑ Hormonal problems
- ❑ Hormone replacement therapy
- ❑ Interstitial cystitis
- ❑ Irritable bowel
- ❑ Irregular periods
- ❑ Just don't feel like myself
- ❑ Lack of periods
- ❑ Low sex drive
- ❑ Lyme disease
- ❑ Menopause symptoms
- ❑ Menstrual cramps
- ❑ Miscarriage
- ❑ Multiple chemical sensitivity
- ❑ Muscle/joint pain
- ❑ Nutritional problems
- ❑ Osteoporosis/osteopenia
- ❑ Pain with intercourse
- ❑ PCOS
- ❑ PMS
- ❑ Poor diet
- ❑ Post chemotherapy health problems
- ❑ Preconception preparation
- ❑ Second opinion for surgery
- ❑ Sleep problems
- ❑ Stress
- ❑ Sugar cravings
- ❑ Thyroid problems
- ❑ Vaginal infections
- ❑ Vaginal itching
- ❑ Vulvar pain
- ❑ Weight problems
- ❑ Other_________________

Your health problem(s) Please write the answers out on a separate page. The answers are VERY important to Dr. Metzger.

- Describe in your own words when and how you symptoms first began.
- How were you functioning on a day-to-day basis (work, leisure, kids, relationships) before your symptoms began?
- How did your symptoms progress over time?
- What type of health care providers did you consult? What was your response to treatment(s)?
- What effect has your health problem had on your job, family, relationships, sexuality, self esteem, depression, etc?
- Of all of the problems in your life, how disruptive is this problem(s)-is it the most important problem you are facing or just one of several issues?
- How are you coping? What are some of your coping strategies?
- What are your expectations of treatment?
- How much responsibility for your health do you want to take?

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What are your attitudes regarding health care (check all that apply):

- ❑ I want to get to the source of the problem, if possible
- ❑ I only want to get rid of the symptoms-give me a prescription
- ❑ I am willing to make life style changes if necessary
- ❑ I prefer natural approaches rather than taking prescription drugs
- ❑ I want to be an active participant in my healthcare
- ❑ I want to learn as much as possible about what is wrong with me
- ❑ I want to know all of the treatment options that are available
- ❑ I don't have much time for my health, just tell me what I have to do

Gynecologic History

How old were you when your periods began?____________

On what date did your last menstrual period begin?______________

If menopausal, when did you stop having periods?___________ Have you had any bleeding or spotting since your last period? ☐ No ☐ Yes

What is the usual number of days in your menstrual cycle from the beginning of one period to the beginning of the next?____________How many days of flow?__________ How many days of spotting?_______________ Are your periods predictable?________

How heavy is your period?

- ❑ Light (panty liner)
- ❑ Moderate/normal
- ❑ Heavy/gushing
- ❑ Very heavy with clots
- ❑ Regularly bleed through protection

Do you have cramps?

- ❑ None
- ❑ Mild
- ❑ Moderate
- ❑ Severe
- ❑ Must stay in bed

Have you ever had sexual intercourse?_____ Number of sexual partners in your lifetime_______ Sexual partners are: ❑ men ❑ women ❑ both

Are there issues you would like to discuss about your sexuality, sexual relationship, or sexual response? ❑ Yes ❑ No

Have you ever had any sexually transmitted diseases?

- ❑ No sexually transmitted diseases
- ❑ AIDS
- ❑ Chlamydia
- ❑ Genital herpes
- ❑ Gonorrhea
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ HIV
- ❑ HPV-genital warts
- ❑ PID-pelvic inflammatory disease
- ❑ Syphilis
- ❑ Trichomoniasis

How many times have you been pregnant?______How many children do you have?____
How many miscarriages?______How many abortions?______ How many ectopics?____

Is future fertility desired? ❑ Yes ❑ No

What is your current method of contraception?

- ❑ Nothing-trying to conceive
- ❑ Nothing-taking chances
- ❑ Nothing-not sexually active
- ❑ IUD-type_______________
- ❑ Condom
- ❑ Birth control pill
- ❑ Rhythm
- ❑ Vasectomy
- ❑ Tubal ligation
- ❑ Diaphragm
- ❑ Cervical cap
- ❑ Hysterectomy
- ❑ Tubal ligation
- ❑ Withdrawal
- ❑ Other__________

Date of last Pap smear__________________ Normal? ❑ Yes ❑ No
Date of last mammogram________________Normal? ❑ Yes ❑ No

Defining your health problems

For each of the symptoms listed below, please indicate the **worst** level of interference with your life over the last month using a 0 to 10 scale, where 0 is no interference with your life and 10 is the worst imaginable.

	0	1	2	3	4	5	6	7	8	9	10
Pelvic pain	O	O	O	O	O	O	O	O	O	O	O
Menstrual cramps	O	O	O	O	O	O	O	O	O	O	O
Pain with intercourse	O	O	O	O	O	O	O	O	O	O	O
Vulvar pain	O	O	O	O	O	O	O	O	O	O	O
Vaginal itching	O	O	O	O	O	O	O	O	O	O	O
Vaginal discharge	O	O	O	O	O	O	O	O	O	O	O
Heavy bleeding with periods	O	O	O	O	O	O	O	O	O	O	O
Irregular periods	O	O	O	O	O	O	O	O	O	O	O
Lack of interest in sex	O	O	O	O	O	O	O	O	O	O	O
PMS symptoms	O	O	O	O	O	O	O	O	O	O	O
Breast tenderness	O	O	O	O	O	O	O	O	O	O	O
Bladder urgency or frequency	O	O	O	O	O	O	O	O	O	O	O
Waking at night to urinate	O	O	O	O	O	O	O	O	O	O	O
Sugar or carb cravings	O	O	O	O	O	O	O	O	O	O	O
Digestion problems	O	O	O	O	O	O	O	O	O	O	O
Bloating	O	O	O	O	O	O	O	O	O	O	O
Muscle/joint pain	O	O	O	O	O	O	O	O	O	O	O
Fatigue/exhaustion	O	O	O	O	O	O	O	O	O	O	O
Muscle weakness	O	O	O	O	O	O	O	O	O	O	O

	0	1	2	3	4	5	6	7	8	9	10
Fever	O	O	O	O	O	O	O	O	O	O	O
Chills	O	O	O	O	O	O	O	O	O	O	O
Night sweats	O	O	O	O	O	O	O	O	O	O	O
Hot flashes	O	O	O	O	O	O	O	O	O	O	O
Brain fog	O	O	O	O	O	O	O	O	O	O	O
Headaches	O	O	O	O	O	O	O	O	O	O	O
Sense of well-being	O	O	O	O	O	O	O	O	O	O	O
Depression	O	O	O	O	O	O	O	O	O	O	O
Anxiety	O	O	O	O	O	O	O	O	O	O	O
Mood swings	O	O	O	O	O	O	O	O	O	O	O
Stress	O	O	O	O	O	O	O	O	O	O	O
Sleep problems	O	O	O	O	O	O	O	O	O	O	O
Hair loss	O	O	O	O	O	O	O	O	O	O	O
Chest pain	O	O	O	O	O	O	O	O	O	O	O
Shortness of breath	O	O	O	O	O	O	O	O	O	O	O
Cough	O	O	O	O	O	O	O	O	O	O	O
Heart palpitations	O	O	O	O	O	O	O	O	O	O	O
Fluid retention or swelling	O	O	O	O	O	O	O	O	O	O	O
Numbness & tingling	O	O	O	O	O	O	O	O	O	O	O
Sharp, shooting pains	O	O	O	O	O	O	O	O	O	O	O
Skin hypersensitivity	O	O	O	O	O	O	O	O	O	O	O
Double or blurry vision	O	O	O	O	O	O	O	O	O	O	O
Buzzing or ringing in the ears	O	O	O	O	O	O	O	O	O	O	O
Dizziness	O	O	O	O	O	O	O	O	O	O	O
Feeling faint when standing up	O	O	O	O	O	O	O	O	O	O	O
Tremur (unavoidable shaking)	O	O	O	O	O	O	O	O	O	O	O
Back pain	O	O	O	O	O	O	O	O	O	O	O
Overall level of functioning	O	O	O	O	O	O	O	O	O	O	O

How have your medical problems affected your life?

Approximately how many days in the past month (30 days) have your activities been:

_____not limited, normal activities possible, minimal or no interference
_____somewhat limited, normal activities possible with effort
_____moderately limited most activities possible but with effort
_____severely limited, some activities possible but with significant effort
_____housebound, few activities possible

Current Medications

What medications are you taking on a regular basis? Include antidepressants, birth control pills, blood pressure medications, vitamins, sleeping pills, Tylenol, Motrin, herbs, supplements, etc

____
____
____
____

Allergies and sensitivities

To what are you allergic or sensitive? Include medications, Latex, metals, tape, suture material, and food allergies, environmental allergens (dust, mold, trees, etc)

Allergy	What kind of reaction?

Have you undergone treatment for allergies?

- ☐ I have no known allergies to molds, weeds, grass, trees, dust, etc.
- ☐ Over the counter medications
- ☐ Prescription antihistamines (Allegra, Zyrtec, Claritin, Hismanal, etc)
- ☐ Nasal sprays (Flonase, Nasalcrom, etc)
- ☐ Leukotriene inhibitors (Accolate, Singulair)
- ☐ Homeopathy
- ☐ NAET, BioSet, Kinesiology, etc.
- ☐ Acupuncture
- ☐ Herbal therapy
- ☐ Allergy desensitization

  What were you experiences with allergy desensitization?

  - ☐ I felt better over time
  - ☐ I felt better, but I still have allergy symptoms
  - ☐ I had an anaphylactic reaction to desensitization
  - ☐ I felt worse with allergy desensitization

Past Medical and Surgical history

Have you been hospitalized for anything beside surgery or childbirth?_________If yes, explain:____

What medical problems have you been treated for and currently are being treated for? ***Check all that apply***

- ❑ Abnormal Pap smears
- ❑ Acne
- ❑ Alcoholism
- ❑ Anxiety
- ❑ Asthma
- ❑ Attention deficit disorder
- ❑ Autoimmune disease
- ❑ Back problems
- ❑ Bipolar disorder
- ❑ Blood clots
- ❑ Bronchitis
- ❑ Cancer
- ❑ Candidiasis
- ❑ Chronic fatigue syndrome
- ❑ Cirrhosis of the liver
- ❑ Crohn’s disease
- ❑ Depression
- ❑ Diabetes-diet controlled
- ❑ Diabetes-oral medications
- ❑ Diabetes-insulin controlled
- ❑ Eczema
- ❑ Epstein Barr virus
- ❑ Excess hair growth
- ❑ Fibrocystic breast disease
- ❑ Fibroids
- ❑ Fibromyalgia
- ❑ Gall stones
- ❑ Gastric ulcer
- ❑ Genetic disease_______________
- ❑ Glaucoma
- ❑ Gout
- ❑ Hair loss
- ❑ Headaches
- ❑ Heart problems
- ❑ Hepatitis, type________________
- ❑ Herpes of the mouth
- ❑ Herpes of the vulva
- ❑ high blood pressure
- ❑ High cholesterol
- ❑ HIV or AIDS
- ❑ Irritable bowel syndrome
- ❑ Kidney failure
- ❑ Kidney stones
- ❑ Lupus
- ❑ Lyme disease
- ❑ Menopausal symptoms
- ❑ Migraines
- ❑ Mitral valve prolapse
- ❑ Multiple sclerosis
- ❑ Mycoplasma
- ❑ Neck disc problems
- ❑ Nerve pain
- ❑ Obsessive compulsive disorder
- ❑ Osteoarthritis
- ❑ Osteopenia
- ❑ Osteoporosis
- ❑ Pancreatitis
- ❑ Phlebitis
- ❑ Polio
- ❑ Polycystic ovaries
- ❑ PMS
- ❑ Psoriasis
- ❑ Raynaud’s disease
- ❑ Restless legs
- ❑ Rheumatoid arthritis
- ❑ Rosacea
- ❑ Schizophrenia
- ❑ Scleroderma
- ❑ Seizures or epilepsy
- ❑ Sicca syndrome (dry eyes)
- ❑ Sjogrens
- ❑ Stomach ulcers
- ❑ Stroke
- ❑ Thyroid problems
- ❑ Tuberculosis
- ❑ Ulcerative colitis
- ❑ Undiagnosed autoimmune disease
- ❑ Urinary frequency/urgency
- ❑ Urinary incontinence
- ❑ Varicose veins
- ❑ None of the above

Please list all of your surgical procedures. **Please provide operative reports for all abdominal or gynecologic procedures.**

Year	Doctor	Hospital, city	Procedures performed

Social history

Current marital status

- ❑ Married
- ❑ Single
- ❑ Widowed
- ❑ Civil union
- ❑ Separated
- ❑ Divorced
- ❑ Committed relationship

Who do you live with?____

Who are the people you talk to concerning your health or during stressful times?

- ❑ Spouse/partner
- ❑ Friend
- ❑ Relative
- ❑ Doctor
- ❑ Nurse
- ❑ Support group
- ❑ Mental health professional
- ❑ Clergy
- ❑ I take care of it myself

How does your partner/spouse/significant other deal with your health problems?

- ❑ Doesn't notice
- ❑ Withdraws
- ❑ Distracts me with activities
- ❑ Actively helps look for solutions
- ❑ Takes care of me
- ❑ Feels helpless
- ❑ Gets angry

Education:

- ❑ Less than 12 years
- ❑ High school graduate or GED
- ❑ Some college
- ❑ College graduate
- ❑ Some graduate school
- ❑ Postgraduate degree

What is your current work status?

- ❑ Employed full time, but regularly work more than 40 hours per week
- ❑ Employed full time, 40 hours per week
- ❑ Employed part time
- ❑ Doing volunteer work
- ❑ Unemployed-looking for work
- ❑ Unemployed-have given up finding work
- ❑ Taking time off from the rat race
- ❑ Full time student
- ❑ Part time student
- ❑ Full time mom
- ❑ Full time homemaker
- ❑ Retired
- ❑ Disabled

How do you get exercise?

- ❑ Couch potato
- ❑ Busy all day
- ❑ Regularly exercise
- ❑ Limited exercise due to health problems
- ❑ Can't exercise at all
- ❑ Housebound

How much time do you allow for sleep each night?_________

How many hours of sleep do you get each night?___________

What is your diet like? *Check all that apply.*

- ❑ High carbohydrate
- ❑ Low carbohydrate
- ❑ Low glycemic
- ❑ Low fat
- ❑ Sweet tooth
- ❑ Vegetarian
- ❑ Vegan
- ❑ Macrobiotic
- ❑ Meat
- ❑ Fish
- ❑ Dairy products
- ❑ Fruits & vegetables
- ❑ Anti-candida diet
- ❑ Fast food
- ❑ Junk food
- ❑ Calcium supplements
- ❑ Vitamin supplements

Have you ever had an eating disorder such as anorexia or bulimia? ❑ Yes ❑ No

How many cups (8 ounces) of caffeine do you drink per day? Include coffee, tea, soda. Remember that a Starbucks grande is 3 cups (24 oz) and most coffee cups are at least 12 oz. (1½ cups)

- ❑ None, everything is decaffeinated
- ❑ 1-2 cups
- ❑ 2-4 cups
- ❑ 4-6 cups
- ❑ >6 cups

Have you ever smoked cigarettes? __________ When?______________________
Do you currently smoke? ___________
How many cigarettes per day? __________

How many alcoholic drinks to you have per week?_____Do you, your family or friends criticize the amount you drink?____Do you feel guilty about the amount you drink?____ Do you drink in the morning?_____Do you drink to treat your symptoms ?____________

Which of the following have you used in the past or are currently using?

- ❑ Heroin
- ❑ Barbiturates
- ❑ Amphetamines
- ❑ Cocaine
- ❑ Marijuana
- ❑ Other____________

Have you ever received treatment for substance abuse? ❑ Yes ❑ No

Have you ever been the victim of sexual abuse as a child (less than 14 years old)? This can include exposure of someone's sex organs or touching your sex organs without your consent.
.

❑ No ❑ Yes ❑ Not sure

Have you ever been the victim of physical abuse by a family member, spouse or boyfriend? This can include being hit, kicked, or beaten.

❑ Never ❑ Seldom ❑ Occasionally ❑ Often

Have you ever been the victim of emotional abuse? This can include being humiliated or insulted.

❑ Never ❑ Seldom ❑ Occasionally ❑ Often

Are you in a relationship with someone who has ever physically hurt or threatened you?________ When you disagree at home, are you ever afraid of what your partner might do to you, your children, or your possessions?_________ Does your partner ever try to control what you do, where you go, your money, or relationships with your family and friends?_______ Does your partner ever force you to engage in unwanted sex or sex that makes you feel uncomfortable?________

Family History

Relative	Age	Health problems
Mother		
Father		
Sisters		
Brothers		
Children		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		

Do any of the following health problems run in your family? *Check all that apply.*

- ❑ Alcoholism
- ❑ Allergies
- ❑ Alzheimer's disease
- ❑ Anemia
- ❑ Asthma
- ❑ Birth defects
- ❑ Bleeding problems
- ❑ Blood clots
- ❑ Breast cancer
- ❑ Celiac disease
- ❑ Chromosomal defects
- ❑ Cystic fibrosis
- ❑ Depression
- ❑ Diabetes
- ❑ Down syndrome
- ❑ Endometriosis
- ❑ Genetic disorders
- ❑ Heart attack
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Huntington's Chorea
- ❑ Mental retardation
- ❑ Osteoporosis
- ❑ Ovarian cancer
- ❑ Psychiatric disorders
- ❑ Sickle cell anemia
- ❑ Stroke
- ❑ Substance abuse
- ❑ Suicide
- ❑ Tay sachs disease
- ❑ Thyroid problems
- ❑ Tuberculosis

*Review of systems***.** Please check all that apply to you.

Constitutional

- ☐ Night sweats
- ☐ Trouble sleeping
- ☐ Low grade fevers
- ☐ Flu-like symptoms
- ☐ Loss of energy
- ☐ Fatigue

Emotional

- ☐ Anxiety
- ☐ Panic attacks
- ☐ Mood swings
- ☐ Depression
- ☐ Irritability
- ☐ Frequent crying spells
- ☐ Feel hopeless
- ☐ Obsessive-compulsive
- ☐ Bipolar
- ☐ Hallucinations
- ☐ Hyperactivity
- ☐ Feeling of rage
- ☐ Apathy
- ☐ Nervousness
- ☐ Drug or alcohol issues
- ☐ Self injury
- ☐ Lack of interest in usual activities
- ☐ Think of suicide sometimes
- ☐ Jekyll & Hyde personality

Head & neck

- ☐ Dry eyes
- ☐ Night blindness
- ☐ Visual problems
- ☐ Nose bleeds
- ☐ Dry mouth
- ☐ Metallic taste in mouth
- ☐ Coated tongue
- ☐ Speech problems
- ☐ Canker sores
- ☐ Sores in the corner of the mouth
- ☐ Toothache
- ☐ Bleeding gums
- ☐ Mercury amalgams
- ☐ Root canals
- ☐ Numbness or tingling in lips or tongue
- ☐ Difficulty hearing
- ☐ Ringing in the ears
- ☐ Frequent sore throats
- ☐ Swollen glands

Respiratory

- ☐ Shortness of breath
- ☐ Shortness of breath with exercise
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Exposure to TB
- ☐ Chronic cough
- ☐ Asthma

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart murmur
- ☐ Mitral valve prolapse
- ☐ Passing out
- ☐ Dizziness with standing
- ☐ Heart palpitations
- ☐ Lips turn blue sometimes
- ☐ Swelling of legs
- ☐ Pain in legs with walking
- ☐ Chest pain
- ☐ High cholesterol
- ☐ High triglycerides

Hematologic

- ☐ Bleeding tendency
- ☐ Anemia
- ☐ Blood clots
- ☐ Blood transfusion
- ☐ Swollen glands
- ☐ Easy bruising

Gastrointestinal

- ❑ Always hungry
- ❑ Belching
- ❑ Bloating
- ❑ Blood with bowel movements
- ❑ Burping
- ❑ Constipation
- ❑ Diarrhea
- ❑ Difficulty passing stool
- ❑ Abnormal liver function tests
- ❑ Feeling of incomplete emptying after a bowel movement
- ❑ Fewer than 3 bowel movements a week
- ❑ Flatulence
- ❑ Food cravings
- ❑ Foul smelling gas
- ❑ Hard or lumpy stools
- ❑ Heartburn
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Intestinal cramps
- ❑ Intestinal gas
- ❑ Light colored stools
- ❑ Liver disease
- ❑ Loose or watery stools
- ❑ Loss of appetite
- ❑ Loss of control over bowel movements
- ❑ More than 3 bowel movements a day
- ❑ Nausea
- ❑ Pain with bowel movements
- ❑ Passing mucus (slippery white material) during a bowel movement
- ❑ Stomach aches
- ❑ Stomach ulcers
- ❑ Stools that float
- ❑ Straining during bowel movements
- ❑ Urgency-having to rush to the bathroom for a bowel movement
- ❑ Vomiting
- ❑ Yellow color to the eyes

Gyn

- ❑ Low sexual desire
- ❑ Breast lump/cyst
- ❑ Breast pain
- ❑ Discharge from nipple
- ❑ Abnormal Pap smear
- ❑ Sexual difficulties
- ❑ Genital sores
- ❑ Postmenopausal bleeding
- ❑ Bleeding or spotting after intercourse
- ❑ Dissatisfied with current birth control method

Urinary tract

- ❑ Bladder infections
- ❑ Difficulty starting urination
- ❑ Feeling of incomplete emptying
- ❑ Kidney problems
- ❑ Frequent urination
- ❑ Getting up at night to urinate
- ❑ Interstitial cystitis
- ❑ Loss of urine with coughing, sneezing, exercise

Neurologic

- ❑ Confusion
- ❑ Difficulty concentrating
- ❑ Difficulty with balance
- ❑ Fainting
- ❑ Forgetfulness
- ❑ Hallucinations
- ❑ Headaches
- ❑ Learning disability
- ❑ Lose things all the time
- ❑ Numbness
- ❑ Poor concentration
- ❑ Seizures
- ❑ Poor memory
- ❑ Tingling
- ❑ Trouble walking
- ❑ Difficulty staying on task

Musculoskeletal

- ❑ Back pain
- ❑ Neck pain
- ❑ Herniated discs
- ❑ Sciatica
- ❑ Joint pain
- ❑ Back injury
- ❑ Weakness
- ❑ Muscle aches
- ❑ Muscle cramps
- ❑ Leg pain
- ❑ Fibromyalgia
- ❑ Numbness or tingling in hands or feet
- ❑ Feel like you've been 'hit by a truck' the day after exercise

Skin:

- ❑ Flushing
- ❑ Pallor-paleness
- ❑ Acne
- ❑ Dry skin
- ❑ Oily skin
- ❑ Flaky skin
- ❑ Dandruff
- ❑ Abnormal finger nails
- ❑ Athlete's foot
- ❑ Itching
- ❑ Sores
- ❑ Eczema
- ❑ Rashes
- ❑ Psoriasis
- ❑ Excessive body odor
- ❑ Excessive perspiration

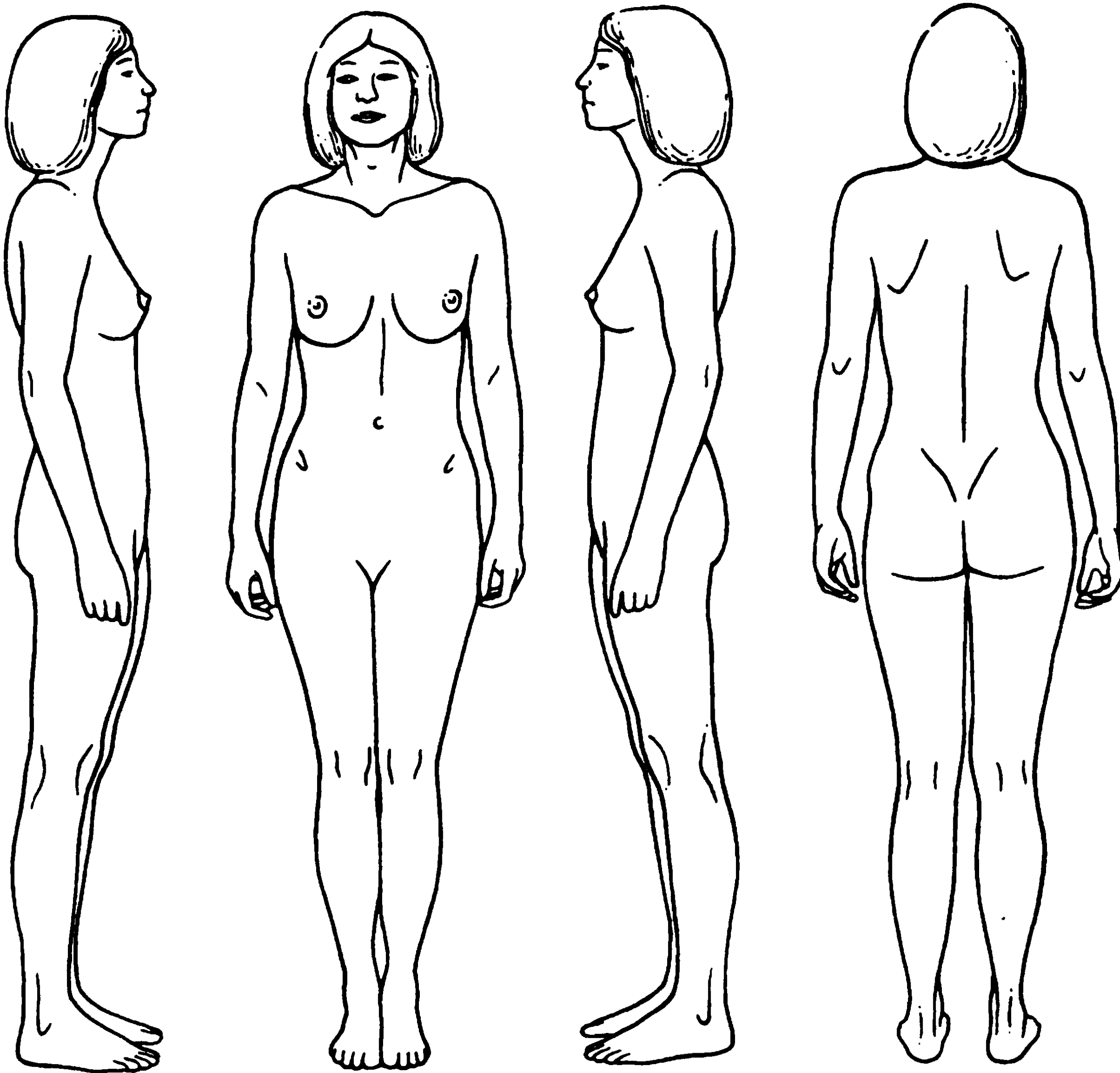
Endocrine

- ❑ Craving sweets, bread or pasta
- ❑ Excessive thirst
- ❑ Excessive urination
- ❑ Hot flashes
- ❑ Hypoglycemia
- ❑ Low body temperature ($<98^0$)
- ❑ Thyroid problems
- ❑ Heat intolerance
- ❑ Cold intolerance
- ❑ Hair loss
- ❑ Weight gain
- ❑ Unwanted weight loss
- ❑ Thin hair
- ❑ Decrease in arm and Leg hair

Allergic & Immune

- ❑ Asthma
- ❑ Chronic bronchitis
- ❑ Sinus headaches
- ❑ Seasonal allergies
- ❑ Sinus infections
- ❑ Eczema
- ❑ Wheezing
- ❑ Dry cough
- ❑ Multiple chemical sensitivity
- ❑ Post nasal drip
- ❑ Anaphylactic reactions
- ❑ Slow recovery from viruses

If you are having pain, please draw your pain on the diagram.



Use the following symbols to mark the figures above with the location of your pain:

■ localized severe pain
⚅ general area of pain
Pain starts at this point ■ and travels to where the arrow is ⟶