

Harmony Health

General Male History Form

Name: _____

Date: _____

Information about your health

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

- | | | |
|--|--|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Emotional problems | <input type="checkbox"/> Muscle/joint pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fatigue/exhaustion | <input type="checkbox"/> Nutritional problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fertility issues | <input type="checkbox"/> Osteoporosis/osteopenia |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Fevers | <input type="checkbox"/> Poor diet |
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> General health improvement | <input type="checkbox"/> Post chemotherapy health problems |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Preconception preparation |
| <input type="checkbox"/> Brain fog | <input type="checkbox"/> Headaches | <input type="checkbox"/> Second opinion for surgery |
| <input type="checkbox"/> Cancer survivor | <input type="checkbox"/> Hormonal problems | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Candida | <input type="checkbox"/> Interstitial cystitis | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Carbohydrate cravings | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Sugar cravings |
| <input type="checkbox"/> Chronic pelvic pain | <input type="checkbox"/> Just don't feel like myself | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Low sex drive | <input type="checkbox"/> Weight problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Disease prevention | <input type="checkbox"/> Multiple chemical sensitivity | |

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?

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

	0	1	2	3	4	5	6	7	8	9	10
Heart palpitations	0	0	0	0	0	0	0	0	0	0	0
Fluid retention or swelling	0	0	0	0	0	0	0	0	0	0	0
Numbness & tingling	0	0	0	0	0	0	0	0	0	0	0
Sharp, shooting pains	0	0	0	0	0	0	0	0	0	0	0
Skin hypersensitivity	0	0	0	0	0	0	0	0	0	0	0
Double or blurry vision	0	0	0	0	0	0	0	0	0	0	0
Buzzing or ringing in the ears	0	0	0	0	0	0	0	0	0	0	0
Dizziness	0	0	0	0	0	0	0	0	0	0	0
Feeling faint when standing up	0	0	0	0	0	0	0	0	0	0	0
Tremur (unavoidable shaking)	0	0	0	0	0	0	0	0	0	0	0
Back pain	0	0	0	0	0	0	0	0	0	0	0
Overall level of functioning	0	0	0	0	0	0	0	0	0	0	0

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

To what extent are the following areas of your life affected in a negative way by your health problems?

- 0-not affected
 1-rarely affected
 2-occasionally affected
 3-frequently affected
 4-regularly affected
 5-not able to do

	0	1	2	3	4	5
relationship with your partner/spouse	0	0	0	0	0	0
leisure activities	0	0	0	0	0	0
sleeping patterns	0	0	0	0	0	0
climbing stairs	0	0	0	0	0	0
bathing or dressing yourself	0	0	0	0	0	0
mood	0	0	0	0	0	0
interest in sex	0	0	0	0	0	0
frequency of orgasm	0	0	0	0	0	0
light housework/yardwork	0	0	0	0	0	0
caring for your children	0	0	0	0	0	0

	0	1	2	3	4	5
shopping	0	0	0	0	0	0
ability to concentrate	0	0	0	0	0	0
appetite	0	0	0	0	0	0
your job	0	0	0	0	0	0
relationships with others	0	0	0	0	0	0
social activities	0	0	0	0	0	0
general enjoyment of life	0	0	0	0	0	0
walking	0	0	0	0	0	0
enjoyment of sex	0	0	0	0	0	0
frequency of sex	0	0	0	0	0	0

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

Medication	Dose	Prescribing Doctor

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?

- Over the counter medications
- Prescription antihistamines (Allegra, Zyrtec, Claritin, Hismanal, etc)
- Nasal sprays (Flonase, Nasalcrom, etc)
- Sodium cromolyn inhalers (Vancenase, Becanase)
- Other inhalers (Advair, Proventil, Ventolin, Alupent)
- Leukotriene inhibitors (Accolate, Singulair)
- Homeopathy
- 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 ? _____ If yes, explain: _____

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Herpes of the mouth |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Depression | <input type="checkbox"/> Herpes of the genitals |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes-diet controlled | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Alopecia (hair loss) | <input type="checkbox"/> Diabetes-oral medications | <input type="checkbox"/> Hypertension (high blood pressure) |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes-insulin controlled | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Attention deficit disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney failure |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Epstein Barr virus | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Back disc problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Gall stones | <input type="checkbox"/> Lyme disease |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Gastric ulcer | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Genetic disease _____ | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Mycoplasma |
| <input type="checkbox"/> Candidiasis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Neck disc problems |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Heart arrhythmia | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Heart attack | |
| <input type="checkbox"/> Cirrhosis of the liver | <input type="checkbox"/> Hepatitis | |

Social history

Current marital status

- Married Widowed Separated Committed relationship
 Single Civil union Divorced

Who do you live with? _____

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

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

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

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

Education:

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

What is your current work status?

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

How do you get exercise?

- Couch potato Physically demanding job Can't exercise at all
 Busy all day Regularly exercise Housebound
 Weekend warrior Limited exercise due to health problems
 Running after the kids

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.*

- | | | |
|--|--|--|
| <input type="checkbox"/> High carbohydrate | <input type="checkbox"/> Vegan | <input type="checkbox"/> Fast food |
| <input type="checkbox"/> Low carbohydrate | <input type="checkbox"/> Macrobiotic | <input type="checkbox"/> Junk food |
| <input type="checkbox"/> Low glycemic | <input type="checkbox"/> Meat | <input type="checkbox"/> Low fat |
| <input type="checkbox"/> Caffeine to wake up
& function | <input type="checkbox"/> Fish | <input type="checkbox"/> Iron supplements |
| <input type="checkbox"/> Sweet tooth | <input type="checkbox"/> Dairy products | <input type="checkbox"/> Calcium supplements |
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Fruits & vegetables | <input type="checkbox"/> Vitamin supplements |
| | <input type="checkbox"/> Anti-candida diet | |

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)

- | | |
|--|-----------------------------------|
| <input type="checkbox"/> None, everything is decaffeinated | <input type="checkbox"/> 4-6 cups |
| <input type="checkbox"/> 1-2 cups | <input type="checkbox"/> >6 cups |
| <input type="checkbox"/> 2-4 cups | |

Have you ever smoked cigarettes? _____

Do you currently smoke? _____

How many cigarettes per day? _____

For how long have you smoked? _____

How many alcoholic drinks do 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?

- | | | |
|---------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Heroin | <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Marijuana |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Cocaine | <input type="checkbox"/> 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.

- Yes No 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?_____

Sexual History

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?

- | | | |
|---|--|--|
| <input type="checkbox"/> No sexually transmitted diseases | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> PID-pelvic inflammatory disease |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Trichomoniasis |
| <input type="checkbox"/> Genital herpes | <input type="checkbox"/> HIV | |
| <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> HPV-genital warts | |

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.*

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

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

Constitutional

- | | | |
|---|---|---|
| <input type="checkbox"/> Low grade fevers | <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Fatigue after meals |
| <input type="checkbox"/> Flu-like symptoms | <input type="checkbox"/> Loss of energy | <input type="checkbox"/> Fatigue in the morning |
| <input type="checkbox"/> Chronic fatigue syndrome | <input type="checkbox"/> Chemical exposure | |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Fatigue all the time | |

Emotional

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

Head & neck

- | | | |
|--|--|--|
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Double vision | <input type="checkbox"/> Frequent sore throats |
| <input type="checkbox"/> Visual problems | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Speech problem |

- | | | |
|---|---|---|
| <input type="checkbox"/> Sores in the corner of the mouth | <input type="checkbox"/> Mercury amalgams | <input type="checkbox"/> Night blindness |
| <input type="checkbox"/> Canker sores | <input type="checkbox"/> Gum disease | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Metallic taste in mouth | <input type="checkbox"/> Fissures of the tongue |
| <input type="checkbox"/> Coated tongue | <input type="checkbox"/> Numbness or tingling in lips or tongue | <input type="checkbox"/> Swelling in the neck |
| <input type="checkbox"/> Toothache | <input type="checkbox"/> Abnormal tongue surface | <input type="checkbox"/> Swollen lymph nodes |

Respiratory

- | | | |
|--|--|---|
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Exposure to TB |
| <input type="checkbox"/> Shortness of breath with exercise | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chronic cough |
| | <input type="checkbox"/> Wheezing | |

Cardiovascular

- | | | |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Swelling of legs |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Passing out | <input type="checkbox"/> Pain in legs with walking |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Dizziness with standing | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Lips turn blue sometimes | <input type="checkbox"/> High triglycerides |

Hematologic

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Swollen glands | |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Easy bruising | |

Gastrointestinal

- | | | |
|---|--|--|
| <input type="checkbox"/> Abdominal fullness, bloating or swelling | <input type="checkbox"/> Feeling of incomplete emptying after a bowel movement | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Always hungry | <input type="checkbox"/> Fewer than 3 bowel movements a week | <input type="checkbox"/> Loose or watery stools |
| <input type="checkbox"/> Bloating 1-2 hours after eating | <input type="checkbox"/> More than 3 bowel movements a day | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Bloating soon after eating | <input type="checkbox"/> Flatulence | <input type="checkbox"/> Loss of control over bowel movements |
| <input type="checkbox"/> Blood with bowel movements | <input type="checkbox"/> Food cravings | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Burping | <input type="checkbox"/> Foul smelling gas | <input type="checkbox"/> Pain with bowel movements |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hard or lumpy stools | <input type="checkbox"/> Passing mucus (slippery white material) during a bowel movement |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Difficulty passing stool | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stools that float |
| <input type="checkbox"/> Abnormal liver function tests | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Straining during bowel movements |
| | <input type="checkbox"/> Intestinal cramps | <input type="checkbox"/> Urgency-having to rush to the bathroom for a bowel movement |
| | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Vomiting |
| | <input type="checkbox"/> Light colored stools | <input type="checkbox"/> Yellow color to the eye |

Genito-Urinary tract

- | | | |
|---|--|---|
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Breast lump/cyst | <input type="checkbox"/> Mumps, age_____ |
| <input type="checkbox"/> Change in color of urine | <input type="checkbox"/> Sexual difficulties | <input type="checkbox"/> Orchitis |
| <input type="checkbox"/> Change in odor of urine | <input type="checkbox"/> Difficulty getting or maintaining an erection | <input type="checkbox"/> Poor sense of smell |
| <input type="checkbox"/> Difficulty in starting urination | <input type="checkbox"/> Genital sores | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Feeling of incomplete emptying | <input type="checkbox"/> Fertility problems | <input type="checkbox"/> Retrograde ejaculation |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Epididymitis | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Testicular injury |
| <input type="checkbox"/> Getting up at night to urinate | <input type="checkbox"/> Genital warts | <input type="checkbox"/> Testicular tumor |
| <input type="checkbox"/> Low sexual desire | <input type="checkbox"/> Hernia surgery | <input type="checkbox"/> Undescended testicles |
| | <input type="checkbox"/> Herpes | <input type="checkbox"/> Varicocele repair |
| | <input type="checkbox"/> Low sperm count | <input type="checkbox"/> Vasectomy |
| | | <input type="checkbox"/> Vasectomy reversal |

Neurologic

- | | | |
|---|---|---|
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Lose things all the time | <input type="checkbox"/> Trouble walking |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Numbness | <input type="checkbox"/> Difficulty staying on task |
| <input type="checkbox"/> Difficulty with balance | <input type="checkbox"/> Poor concentration | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Poor memory | |
| <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Poor short term memory | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Seizures | |

Musculoskeletal

- | | | |
|--|---|--|
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness or tingling in hands or feet |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Feel like you've been 'hit by a truck' the day after exercise |
| <input type="checkbox"/> Herniated discs | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Sciatica | <input type="checkbox"/> Leg pain | |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Fibromyalgia | |
| <input type="checkbox"/> Back injury | <input type="checkbox"/> Autoimmune disease | |

Skin:

- | | | |
|--|--|---|
| <input type="checkbox"/> Flushing | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Vitiligo (skin patches that don't tan) |
| <input type="checkbox"/> Pallor-paleness | <input type="checkbox"/> Abnormal finger nails | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Athlete's foot | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Itching | <input type="checkbox"/> Excessive body odor |
| <input type="checkbox"/> Oily skin | <input type="checkbox"/> Sores | <input type="checkbox"/> Excessive perspiration |
| <input type="checkbox"/> Flaky skin | <input type="checkbox"/> Eczema | |

Endocrine

- | | | |
|---|---|---|
| <input type="checkbox"/> Craving sweets, bread or pasta | <input type="checkbox"/> Low body temperature (<98 ⁰) | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Unwanted weight loss |
| <input type="checkbox"/> Excessive urination | <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Thin hair |
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Decrease in arm and Leg hair |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Hair loss | |

Allergic & Immune

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies to mold | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Multiple chemical sensitivity |
| <input type="checkbox"/> Allergies to trees, grass, weeds | <input type="checkbox"/> Sinus infections | <input type="checkbox"/> Post nasal drip |
| <input type="checkbox"/> Allergies to pets | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Anaphylactic reactions |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Slow recovery from viruses |
| <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Wheezing | |
| <input type="checkbox"/> Sinus headaches | <input type="checkbox"/> Dry cough | |

Is there anything that you would like to add that we haven't asked? _____
