MEDICAL SYMPTOMS QUESTIONNAIRE

DATE_____ DR_____ PATIENT_____ #_____

Rate each of the following symptoms based upon your typical health profile for:

☐ Past 30 days ☐ Past 48 hours Week_____

Point Scale
0 - *Never* or *almost never* have the symptom
1 - *Occasionally* have it, effect is *not severe*
2 - *Occasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

HEAD	_____	Headaches	
	_____	Faintness	
	_____	Dizziness	
	_____	Insomnia	Total_____
EYES	_____	Watery or itchy eyes	
	_____	Swollen, reddened, or sticky eyelids	
	_____	Bags or dark circles under eyes	
	_____	Blurred or tunnel vision	
		(does not include near- or far-sightedness)	Total_____
EARS	_____	Itchy ears	
	_____	Earaches, ear infections	
	_____	Drainage from ear	
	_____	Ringing in ears, hearing loss	Total_____
NOSE	_____	Stuffy nose	
	_____	Sinus problems	
	_____	Hay fever	
	_____	Sneezing attacks	
	_____	Excessive mucus formation	Total_____
MOUTH/THROAT	_____	Chronic coughing	
	_____	Gagging, frequent need to clear throat	
	_____	Sore throat, hoarseness, loss of voice	
	_____	Swollen or discolored tongue, gums, lips	
	_____	Canker sores	Total_____
SKIN	_____	Acne	
	_____	Hives, rashes, dry skin	
	_____	Hair loss	
	_____	Flushing, hot flashes	
	_____	Excessive sweating	Total_____
HEART	_____	Irregular or skipped heartbeat	
	_____	Rapid or pounding heartbeat	
	_____	Chest pain	Total_____

OVER ➔

DATE_____ DR_____ PATIENT_____ #_____

Point Scale

0 - *Never* or *almost never* have the symptom
1 - *Occasionally* have it, effect is *not severe*
2 - *Occasionally* have it, effect is *severe*
3 - *Frequently* have it, effect is *not severe*
4 - *Frequently* have it, effect is *severe*

LUNGS	_____	Chest congestion	
	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	Total_____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	Total_____
JOINTS/ MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	Total_____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Compulsive eating	
	_____	Water retention	
	_____	Underweight	Total_____
ENERGY/ ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	Total_____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Poor concentration	
	_____	Poor physical coordination	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	Total_____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	Total_____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	Total_____

BOTH SIDE TOTAL _____

Date_____ Dr._____ Patient_____ #_____

HEALTH EVALUATION QUESTIONNAIRE

1. How many cups of REGULAR coffee do you drink @ breakfast? _____
   @ lunch? _____
   @ dinner? _____
   in between or at other times? _____

2. How many cups of de-caffeinated coffee do you drink @ breakfast? _____
   @ lunch? _____
   @ dinner? _____
   in between or at other times? _____

3. How many regular pops _____ or diet pops _____ do you drink per day?

4. How many cups of tea do you drink per day? _____
   What type of tea do you drink? _____

5. How many teaspoons of regular sugar do you use in each cup of tea or coffee? _____

6. Do you use artificial sweetener? ☐ Yes/No ☐
   What type? _____
   Do you use honey? ☐ Yes/No ☐

7. Do you usually eat some type of dessert after lunch? ☐ Yes/No ☐
   after dinner? ☐ Yes/No ☐
   Do you usually eat some type of dessert for snacks or other times during the day? ☐ Yes/No ☐

8. What things do you eat for snacks?_____

9. What do you usually eat for breakfast? _____

10. What do you usually eat for lunch?_____

11. What do you usually eat for dinner?_____

12. What hours do you work out of the house (e.g. 8 a.m. - 5 p.m.) _____

13. What hours do you usually sleep (e.g. 11 p.m. - 6 a.m.) _____

14. How many cocktails or alcoholic drinks do you usually have @ lunch? _____
    @dinner? _____
    at other times? _____

15. What type of alcohol do you prefer?_____

16. How many social functions do you attend per month in which you drink alcoholic beverages? _____

17. How many drinks do you usually have at each function? _____

18. Do you usually salt your food during cooking? ☐ Yes/No ☐

19. Do you usually salt foods at the table while eating? ☐ Yes/No ☐

20. Do you sometimes salt your food at the table before tasting it? ☐ Yes/No ☐

21. Do you use monosodium glutamate ("Accent")? ☐ Yes/No ☐

22. Do you have softened water at home? ☐ Yes/No ☐
    at work? ☐ Yes/No ☐

23. How many packs of cigarettes do you smoke per day? _____

24. How often do you go one pack over? _____

Date_____ Dr._____ Patient_____ #_____

25. How many cigars do you smoke per day? _____

26. Do you smoke a pipe? _____

27. How many times per week do you eat luncheon meats? _____

28. How many times per week do you eat hot dogs? _____

29. Do you often eat charcoal-grilled meats in restaurants or on your barbecue grill? _____

30. How many times per week do you eat bacon? _____

31. Do you usually eat canned or fresh or frozen vegetables? Canned/Fresh/Frozen

32. Name the prescription drugs which you take regularly._____
Birth control pills?_____

33. Name the non-prescription drugs which you take regularly._____

34. Do you work/live in an environment of fumes, chemicals, gases, etc.? ☐ Yes/No ☐
What?_____

35. Which of your relatives have/had any of the following problems (indicate by number):

_____ Father	_____ Sisters	_____Sons	_____ Father's mother
_____ Mother	_____ Uncles	_____Daughters	_____ Mother's father
_____ Brothers	_____ Aunts	_____Father's father	_____ Mother's mother

(**1**)Cancer (**2**)Blood sugar (Diabetes) (**3**)Arthritis (**4**)Heart disease, high blood pressure (**5**)Alcohol problems
(**6**)Spastic colon, colitis (**7**)Headaches (**8**)Nerve, mental problem (**9**)Gallbladder or urinary (**10**)Good health
You may list more than one number for each relative.

36. Do you perform any regularly scheduled exercise? ☐ Yes/No ☐

37. Is there a lot of exercise in your job? ☐ Yes/No ☐
What?_____

38. What is the name of the hair shampoo that you use? _____

39. Do you have a "permanent", "cold-wave" or dye treatment in your hair now? ☐ Yes/No ☐

40. Do you often feel "bloated" or excessively full after eating? ☐ Yes/No ☐

41. Do you usually drink liquids with your meals? ☐ Yes/No ☐
How many glasses/cups? _____

42. Do you have a lot of stomach gas, belching? ☐ Yes/No ☐

43. Do you have a lot of bowel gas, flatulence? ☐ Yes/No ☐

44. How often do you move your bowels?
several x/day 1-2x/day 3-4x/week 1-2x/weekly once in 10-15 days once/month

45. Is your stool usually loose or formed consistency? ☐ L / F ☐

46. Indicate the usual color of your stool: ☐ white ☐ yellow ☐ light brown ☐ brown ☐ dark brown ☐ black

47. Are there usually undigested food particles in your stool? ☐ Yes/No ☐

48. How many glasses of milk do you drink daily? _____

49. Which vitamins do you take?_____

Patient Signature_____

Date: _____ Dr. _____ Pt. _____ #_____

CONFIDENTIAL HRT QUESTIONNAIRE SECTION 1

Place the appropriate number (0-3) next to each of the symptoms listed below.

0 = None present 1 = Mild 2 = Moderate 3 = Severe

___ Hot flashes

___ Sugar cravings

___ Water retention/Bloatedness

___ Mood swings

___ Irritability

___ High Blood Pressure • Blood pressure medication

___ Insomnia (lack of restful sleep)

___ Decreased libido (decreased sex drive)

___ Vaginal dryness

___ Swollen breasts

___ Breast tenderness

___ Fibrocystic breasts

___ Uterine fibroids (past or present)

___ Depression

___ Inability to handle stress

___ Fatigue

___ Feeling of always being cold

___ Dry, wrinkling skin

___ Headaches

___ Foggy thinking

___ Memory loss

___ Loss of concentration

___ Irregular periods

___ Monthly cramping

___ Menstrual Cycle PLEASE CHECK
☐ Light periods
☐ Heavy periods

___ PMS (other) PLEASE CHECK
☐ Anxiety
☐ Craving
☐ Dizziness
☐ Crying

___ Weight gain

___ Fat accumulation at hips or abdomen

___ Body aches & pains

___ Hair loss

___ Allergy - type symptoms

___ Sluggishness in the morning

___ Gallbladder problems

___ Blood sugar problems (high, low, diabetes, or hypoglycemia)

___ Blood clotting problems. Explain:_____

TOTAL: _____

OVER PLEASE

Date: _____ Dr. _____ Pt. _____ #_____

PLACE A CHECK IN THE APPROPRIATE BOX FOR EACH QUESTION. **SECTION 2**

PLEASE ANSWER EVERY QUESTION COMPLETELY. What is your current age? _____

1. Do you have osteoporosis? ☐ Yes ☐ No ☐ Unsure

2A. Have you ever had a fracture? ☐ Yes ☐ No ☐ Unsure

2B. Have you had a hysterectomy? ☐ Yes ☐ No Ovaries removed ☐ Yes ☐ No

3. What was the **first day** of your **last** menstrual period? _____

4. Are your periods regular? ☐ Yes ☐ No How many days apart? _____

5. At what age did your periods first begin? _____

6. When was your last visit to your gynecologist? _____

7. Was your exam normal? ☐ Yes ☐ No If no - list the problems _____

8. Have you ever had thyroid problems? ☐ Yes ☐ Low High ☐ No

9. Have you been told, or do you suspect that you have arthritis? ☐ Yes ☐ No

10. Have you ever had endometriosis? ☐ Yes ☐ No

11. Have you ever had a stroke (or TIA)? ☐ Yes, Date _____ ☐ No

12. Have you ever had a heart attack? ☐ Yes, Date _____ ☐ No

13. Have you ever had breast cancer? ☐ Yes, Date _____ ☐ No

14. Have you ever had uterine cancer? ☐ Yes, Date _____ ☐ No

15. Do you **currently** take birth control pills? ☐ Yes ☐ No

If yes - list the names: _____

16. Did you **ever** take birth control pills? ☐ Yes ☐ No

If yes - list the names: _____

17. Do you **currently** take any other hormones? ☐ Yes ☐ No

If yes - list them: _____

18. Have you **ever** taken any other hormones? ☐ Yes ☐ No

If yes - list them: _____

19. Do you have any auto-immune disorder? ☐ Yes ☐ No

20. Indicate what foods you **consume daily:** ☐ Meat, ☐ Milk, ☐ Soft Drinks, ☐ Coffee, ☐ Fruit, ☐ Vegetables