PATIENT MEDICAL SYMPTOMS

Please check all symptoms that pertain to you at the current time.

- ☐ Cold hands/feet
- ☐ Fatigue
- ☐ Feverish in the afternoon or flushes
- ☐ Heat sensation in hands, feet, chest
- ☐ Night sweats
- ☐ Catch colds easily
- ☐ Sweats easily during daytime
- ☐ Dizziness
- ☐ See floating black spots

- ☐ Palpitations
- ☐ Sore on tongue
- ☐ Restlessness
- ☐ Anxiety
- ☐ Chest pain
- ☐ Insomnia

- ☐ Cough
- ☐ Sinus congestion
- ☐ Dry mouth, throat, nose, or skin
- ☐ Allergies seasonal or food
- ☐ Chills and fever
- ☐ Stiff neck/shoulders
- ☐ Sore throat
- ☐ Difficult breathing

- ☐ Low appetite
- ☐ Loose stools
- ☐ Constipation
- ☐ Abdominal bloating or gas after eating
- ☐ Feeling tired after eating
- ☐ Prolapsed organs (previously diagnosed)
- ☐ Bruises easily
- ☐ General feeling of heaviness in body
- ☐ Mental heaviness or fogginess
- ☐ Swollen hands/feet
- ☐ Burning sensation after eating
- ☐ Bad breath
- ☐ Large appetite
- ☐ Mouth, canker or cold sores
- ☐ Bleeding, swollen or painful gums
- ☐ Heartburn/belching
- ☐ Stomach pain
- ☐ Vomiting/nausea

- ☐ Diarrhea alternating with constipation
- ☐ Tight/suffocating feeling in chest
- ☐ Bitter taste in mouth
- ☐ Blood shoot eyes/dry eyes
- ☐ Anger easily
- ☐ Skin rashes
- ☐ Headache
- ☐ Numbness of hands and feet
- ☐ Muscle spasms, twitching, cramping
- ☐ Seizures/convulsions

- ☐ Sore, cold or weak knees
- ☐ Low back pain
- ☐ Frequent urination
- ☐ Get up more than once a night to urinate
- ☐ Lack of bladder control
- ☐ Memory problems
- ☐ Hair loss
- ☐ Ringing in ears

Urine is:

☐ Normal color ☐ Clear

☐ Dark yellow ☐ Reddish

☐ Cloudy ☐ Scanty

☐ Bad odor

☐ Burning ☐ Painful

☐ Difficult ☐ Urgent

Libido (sex drive) is:

☐ Normal ☐ Low ☐ High

Women only:

1. Are you pregnant now?

☐ Yes ☐ No

2. Number of children:_________

3. Number of pregnancies:______

4. Age of first period:__________

5. Age of menopause if applicable:________________

6. Is your menses cycle regular?

☐ Yes ☐ No

a. Average number of days in flow:____

b. The flow is:

☐ Normal ☐ Heavy ☐ Light

c. The color is:

☐ red ☐ dark ☐ purple

☐ light brown ☐ brown

d. Do you have the following menstruation related symptoms?

☐ Blood clots

☐ Cramps

☐ Nausea

☐ Breast distension

☐ PMS

☐ Bleeding between periods

☐ Heavy vaginal discharge between periods

e. Birth control:_______________________

Men Only:

☐ Discharge

☐ Pain or swelling of testicles

☐ Ejaculatory problems

☐ Impotence/erectile dysfunction

Signature __________________________

Date_______________________________