Name:      Date:

***Your Health History***

XI/XII

Do you:

Bruise easily

Feel bloated after eating

Get motion sickness when riding

Eat to calm down

Want to lie down after eating

Do you have:

Excessive belching

Excessive gas

A poor appetite

Heartburn or reflux

Nausea

A tendency to be too cold

A tendency to be too hot

Heaviness in your limbs

Eczema or dermatitis

Do you have:

Any skin problems

Trouble digesting fats

Trouble stopping a small cut from bleeding

Swollen feet or ankles

Other swellings or edema

Discomfort in the pit of your stomach

Itchy or burning skin

In the last 6 months, have you:

Gained more than 10 pounds

Lost more than 10 pounds

Lost your interest in eating

Are you:

More thirsty than usual

Always hungry

VII/VIII

Do you have:

Dizziness or vertigo

Headaches more than once a week

Frequent nosebleeds

Tingling or numbness

A bitter or metallic taste in your mouth

A stiff neck

A tic or tremor

Blurry eyesight

Seizures or convulsions

Other eye trouble\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you:

Ever faint or feel faint

Tend to shake or tremble

Often feel irritable or angry

See floaters (little dark dots in your field of vision)

Has your handwriting changed lately

V/VI

Are you:

Disturbed by work problems

Disturbed by family problems

Having any sexual difficulties

Troubled by frightening dreams

Troubled by frightening thoughts

Nervous around strangers

Annoyed by little things

Shy or sensitive

Is it:

Hard to remember

Hard to concentrate

Hard to make decisions

Hard to relax

Do you:

Strongly dislike criticism

Tend to worry

Lose your temper often

Cry often

Usually feel lonely or depressed

Do you have:

A hopeless outlook

A heart murmur

High blood pressure

Low blood pressure

Have you ever had psychiatric help

IX/X

Do you:

Up a lot of phlegm (thick spit)

Cough up blood

Ever have sneezing spells

Get colds more than once a month

Wheeze or have to gasp to breathe

Yawn frequently

Experience painful bowel movements

Do you have:

Shortness of breath

Coughing spells

A runny nose and no cold

A stuffy nose and no cold

Black or bloody bowel movements

Loose bowels for more than a day

Constipation more than twice a month

Bleeding from your rectum

III/IV

Are you:

Anxious often

Fearful often

Exhausted or fatigued a lot

Do you:

Feel cold in general

Frequently get up at night to urinate

Urinate more than 5 or 6 times a day

Wet your pants or wet your bed

Do you have:

Difficulty hearing

Ringing in the ears

Burning or pain when you urinate

Earaches lately

Frequent urinary tract infections

Frequent water retention

Low back pain

Trouble with your teeth

Weak knees

Have your taste senses changed lately

I/II

Are you:

Sweating more than usual

Tired when you wake up

Use sleeping pills regularly

Do you have:

Palpitations

Night sweats

Difficulty staying asleep

Difficulty falling asleep

Cold hands

Cold feet

Sweaty hands

Sweaty feet

**Men**

Do you:

Urine stream weak and slow

Prostate trouble

Any burning or discharge from your penis

Swellings or lumps on your testicles

Are you sexually active?

Are you sexually fulfilled and satisfied?

**Women**

Is your last menstrual period normal?

Yes  No

Are you:

Pre-menopausal or menopausal

Sexually active

Sexually fulfilled and satisfied

Do you:

Have a hysterectomy

Have heavy bleeding during periods

Have excessive cramping

Use contraception and/or condoms?

Have a good sex drive

Have a C-section