

PLEASE PLACE A CHECKMARK NEXT TO ANY CONDITIONS YOU HAVE EXPERIENCED OR ARE CURRENTLY EXPERIENCING.

Cardiovascular System

- Elevated cholesterol
- Sweating associated with pain
- Palpitations
- Swelling of extremities
- History of Smoking
- Orthopnea (difficulty breathing)

G.U. System

- Dysuria (painful urination)
- Hematuria (blood in urine)
- Incontinence
- Frequency of urination
- Urinary urgency
- Vaginal discharge
- Dysmenorrhea (painful menstruation)
- Post-menopausal vaginal bleeding
- Painful intercourse
- Infertility
- History of STD
- Date of Last Period ___/___/___

Neurological System

- Ataxia (poor muscular coordination)
- Memory lapses
- Confusion
- Head Trauma
- Neurological Disorder
- Tremors
- Slurred speech patterns
- Hearing/Visual disturbances

GI System

- Difficulty swallowing
- Heartburn
- Jaundice (yellow appearance)
- Specific food intolerance
- Constipation
- Diarrhea
- Change in color of stool
- Rectal bleeding
- Gall bladder problems
- Liver problems

Pulmonary System

- Dyspnea (labored breathing)
- Wheezing
- Prolonged cough
- Sputum production
Color _____ amount _____

Endocrine System

- Excessive thirst
- Excessive hunger
- Polyuria (large volume of urine)
- Excessive sweating
- Fatigue
- Weakness
- Thyroid problems

Other Systems

- Ear, Nose and Throat
- Integumentary (skin)
- Lymphatic
- Psychiatric
- Musculoskeletal