Mail to:
1201 Richardson Drive
Suite #140
Richardson, TX 75080

Date Survey Completed:______________

First Name:________________ Middle Initial:_____ Last Name:____________________________
Social Security Number:_____-____-_____ Sex: ❑ M ❑ F Date of Birth:____/___/____Current Age:__
Home Address:____
City:___________________________________ State:_____________ Zip:__________________
Home Phone:_(___)___________ Mobile Phone:_(___)___________ Work Phone_(___)_________
E-mail Address:__________________________ Profession:___________ Employer:____________

Referred by (please explain):____
Name of primary care doctor:_____________________________________ Phone:_(___)_________

Reason for today's visit:____
____
____
____

List top 5 symptoms or problems that you would like to see improved? List most important at first and least important last.

1. ____
2. ____
3. ____
4. ____
5. ____

1. If you have children, please provide their age and name: ________________________________
____
____
2. Please check one:

❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed

If married: How long?:_______________

Is he or she supportive?: ❑ Yes ❑ No

What is your spouse's name?: Occupation: __________________________________

1. How many hours now do you currently spend on the following?:

Work:____________________ Children's care:_________________
2. Does your insurance pay for medications?: ❑ Yes ❑ No
3. ❑ Drink non-diet sodas or other sweetened drinks

If so, how many ounces per day?:_______________

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4. ❑ Drink coffee
   If so, how many 8 oz. (American)/240cc (Metric) cups a day?:
   Regular:__________ Decaf:__________
5. ❑ Drink alcohol If so, how many drinks per day on average?:___________
6. ❑ Smoke cigarettes
   If so, how many packs a day?:____________
   For how many years?: __________________
7. ❑ Chew tobacco
8. How much can you exercise at a time?:_______________
9. Besides your illness what other stresses are going on in your life?:_______________________
____
____

10. Please list what medical problems your parents or siblings have or once had? If they died, note cause and approximate age at death:
    Mother:____
    ____
    Father:____
    ____
    Brothers:____
    ____
    Sisters:____
    ____
    Other:____
    ____

11. Allergies/Sensitivities for medications, chemicals, foods, or molds:______________________
____
____
____
____

12. Please list current medications with dosage:____
____
____
____
____
____

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13. Rate severity and frequency of the below symptoms:

Muscle Pain:

Severity:

(No problems) ❒ **0** ❒ **1** ❒ **2** ❒ **3** ❒ **4** ❒ **5** (Moderate) ❒ **6** ❒ **7** ❒ **8** ❒ **9** ❒ **10** (Horrible)

Frequency:

❒ Never ❒ 1/month ❒ 2/month ❒ 3/month ❒ 1-3/week ❒ 4-6/week ❒ Daily ❒ Throughout the day

Stiffness:

(No problems) ❒ **0** ❒ **1** ❒ **2** ❒ **3** ❒ **4** ❒ **5** (Moderate) ❒ **6** ❒ **7** ❒ **8** ❒ **9** ❒ **10** (Horrible)

❒ Never ❒ 1/month ❒ 2/month ❒ 3/month ❒ 1-3/week ❒ 4-6/week ❒ Daily ❒ Throughout the day

Unrefreshing Sleep:

(No problems) ❒ **0** ❒ **1** ❒ **2** ❒ **3** ❒ **4** ❒ **5** (Moderate) ❒ **6** ❒ **7** ❒ **8** ❒ **9** ❒ **10** (Horrible)

❒ Never ❒ 1/month ❒ 2/month ❒ 3/month ❒ 1-3/week ❒ 4-6/week ❒ Daily ❒ Throughout the day

Insomnia:

(No problems) ❒ **0** ❒ **1** ❒ **2** ❒ **3** ❒ **4** ❒ **5** (Moderate) ❒ **6** ❒ **7** ❒ **8** ❒ **9** ❒ **10** (Horrible)

❒ Never ❒ 1/month ❒ 2/month ❒ 3/month ❒ 1-3/week ❒ 4-6/week ❒ Daily ❒ Throughout the day

Daytime Fatigue:

(No problems) ❒ **0** ❒ **1** ❒ **2** ❒ **3** ❒ **4** ❒ **5** (Moderate) ❒ **6** ❒ **7** ❒ **8** ❒ **9** ❒ **10** (Horrible)

❒ Never ❒ 1/month ❒ 2/month ❒ 3/month ❒ 1-3/week ❒ 4-6/week ❒ Daily ❒ Throughout the day

Headaches:

(No problems) ❒ **0** ❒ **1** ❒ **2** ❒ **3** ❒ **4** ❒ **5** (Moderate) ❒ **6** ❒ **7** ❒ **8** ❒ **9** ❒ **10** (Horrible)

❒ Never ❒ 1/month ❒ 2/month ❒ 3/month ❒ 1-3/week ❒ 4-6/week ❒ Daily ❒ Throughout the day

Gastrointestinal Disturbances:

(No problems) ❒ **0** ❒ **1** ❒ **2** ❒ **3** ❒ **4** ❒ **5** (Moderate) ❒ **6** ❒ **7** ❒ **8** ❒ **9** ❒ **10** (Horrible)

❒ Never ❒ 1/month ❒ 2/month ❒ 3/month ❒ 1-3/week ❒ 4-6/week ❒ Daily ❒ Throughout the day

Numbness:

(No problems) ❒ **0** ❒ **1** ❒ **2** ❒ **3** ❒ **4** ❒ **5** (Moderate) ❒ **6** ❒ **7** ❒ **8** ❒ **9** ❒ **10** (Horrible)

❒ Never ❒ 1/month ❒ 2/month ❒ 3/month ❒ 1-3/week ❒ 4-6/week ❒ Daily ❒ Throughout the day

Impaired Concentration:

(No problems) ❒ **0** ❒ **1** ❒ **2** ❒ **3** ❒ **4** ❒ **5** (Moderate) ❒ **6** ❒ **7** ❒ **8** ❒ **9** ❒ **10** (Horrible)

❒ Never ❒ 1/month ❒ 2/month ❒ 3/month ❒ 1-3/week ❒ 4-6/week ❒ Daily ❒ Throughout the day

Sore Throat:

(No problems) ❒ **0** ❒ **1** ❒ **2** ❒ **3** ❒ **4** ❒ **5** (Moderate) ❒ **6** ❒ **7** ❒ **8** ❒ **9** ❒ **10** (Horrible)

❒ Never ❒ 1/month ❒ 2/month ❒ 3/month ❒ 1-3/week ❒ 4-6/week ❒ Daily ❒ Throughout the day

Other: ______________________

(No problems) ❒ **0** ❒ **1** ❒ **2** ❒ **3** ❒ **4** ❒ **5** (Moderate) ❒ **6** ❒ **7** ❒ **8** ❒ **9** ❒ **10** (Horrible)

❒ Never ❒ 1/month ❒ 2/month ❒ 3/month ❒ 1-3/week ❒ 4-6/week ❒ Daily ❒ Throughout the day

Other: ______________________

(No problems) ❒ **0** ❒ **1** ❒ **2** ❒ **3** ❒ **4** ❒ **5** (Moderate) ❒ **6** ❒ **7** ❒ **8** ❒ **9** ❒ **10** (Horrible)

❒ Never ❒ 1/month ❒ 2/month ❒ 3/month ❒ 1-3/week ❒ 4-6/week ❒ Daily ❒ Throughout the day

14. How long have you been fatigued?:____

15. What was the approximate date or time period of the onset?:__________________________

16. How much has fatigue decreased your ability to function in your daily life?:______________

____

17. Have you experienced pain that has decreased your ability to function in your daily life?:

❑ Yes ❑ No

Symptoms began: ❑ Suddenly ❑ Gradually

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18. Was the onset related to any of the following? Please check all that apply:
❑ Major stress ❑ Accident ❑ Infection ❑ Surgery ❑ Medication Other:___________
19. What stresses were occurring in your life when the disease began?: ____________________

____
20. How many hours were you working (including commute but not including taking care of your family) weekly at the onset of your illness?: ___________________________________
21. How many hours were spent weekly on your children's care at onset of your illness?: _______

____
22. To your knowledge, do you have any family members with Fibromyalgia or Chronic Fatigue Syndrome?: ❑ Yes ❑ No
If so, who, what is their age, and how long have they been suffering?:________________

____
23. How many doctors have you seen regarding your symptoms?:______
Check all doctors seen regarding symptoms:
- ❑ Rheumatologist
- ❑ Family physician (general practitioner)
- ❑ Urologist/proctologist
- ❑ Podiatrist (foot doctor)
- ❑ Physical or Occupational Therapist
- ❑ Internist
- ❑ Gastroenterologist
- ❑ General or Orthopedic Surgeon
- ❑ Chiropractor
- Other:__________________

Check all that apply and please give approximate year:
Do you currently have or have you ever had any of these?
24. ❑ Stroke Year:___________________
25. ❑ Multiple Sclerosis Year:___________________
26. ❑ Glaucoma Year: __________________
27. ❑ Cataracts Year: __________________
28. ❑ Lupus Year: __________________
29. ❑ Rheumatoid Arthritis Year: __________________
30. ❑ Osteo Arthritis ("wear & tear" arthritis) Year: __________________
31. ❑ Sclerodern Year: __________________
32. ❑ Neuropathies Year: __________________
What type?:____
33. ❑ Other Rheumatoid diseases Year:___________________
Please list them:____
34. ❑ Phlebitis (Blood Clots) Year: __________________
If so did it go to your lungs? (i.e., Pulmonary Embolus) ❑ Yes ❑ No
35. ❑ Angina (Chest Pain) Year: __________________
36. ❑ Heart attack (Myocardial Infarction) or Coronary Artery Disease Year: _____________
If so was this confirmed by any of the following?:
❑ EKG/Blood Analysis
❑ And/or Exercise stress test
❑ Heart catheterization
❑ Angioplasty
When?:____
❑ Bypass
When?:____

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37. ❑ Mitral Valve Prolapse
38. ❑ Heart valve disease
    Which? Explain:____
39. ❑ Taking blood thinners
    If so, check which one and fill in dose below:
    ❑ Coumadin/Warfarin Mg a day:________________
    ❑ Heparin Mg a day:________________
    ❑ Aspirin Mg a day:________________
    Other Explain:______________________ Mg a day:________________
40. ❑ Diagnosis of abnormal heart rhythm(s) Which type?:________________________
41. ❑ Cancer
    Type:____
    Date of diagnosis:_____________________________________
    ❑ Metastatic (spread) or ❑ Nonmetastatic To where?:______________________
    Is it currently: ❑ Active or ❑ Without Recurrence
    Did you have any of the following?
    ❑ Surgery ❑ Radiation therapy ❑ Chemotherapy
    Other treatment:_______________________________________
42. ❑ Emphysema
43. ❑ Hypertension – high blood pressure
44. ❑ Asthma
45. ❑ Stomach Ulcers
46. ❑ Spastic Colon or Irritable Bowel Syndrome
47. ❑ Crohns' Disease or Ulcerative Colitis Which?:__________________________
48. ❑ AIDS
49. ❑ Polio
50. ❑ Tuberculosis
51. ❑ Other Chronic Infections?
    Please list the type(s):__________________________________
52. ❑ Reflex Sympathetic Dystrophy (RCPS)
    Which extremity?:______________________________________
53. ❑ Recurrent Prostatitis
    Has a bacterial culture ever been positive? ❑ Yes ❑ No
54. ❑ Hepatitis (If so check all that apply):
    ❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C ❑ With infectious Mono
    ❑ Any toxic chemical exposures
    List what exposures and when:_____________________________
55. ❑ Lupus
56. ❑ Alcoholic
57. ❑ Other type of Hepatitis Which?:________________________________
    ❑ Unknown cause
    Are you using herbs?: ❑ Yes ❑ No
    List:____
58. Do you have Cirrhosis?: ❑ Yes ❑ No ❑ Don't know
59. ❑ Have had a liver biopsy

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60. ❑ Have had a blood test to check for high iron levels
61. ❑ Prostate enlargement
62. ❑ Kidney stones
63. ❑ Active Disc Disease (e.g., sciatica)
64. ❑ Kidney Failure
65. ❑ Other kidney Problems? Please describe:_______________________________________
66. ❑ Diabetes
❑ Juvenile onset ❑ Adult onset Dates of Diagnosis:_________

67. ❑ Pancreatitis
❑ Gallstones ❑ Alcohol ❑ Unknown cause
❑ Other known cause Please Explain:_______________________________________

68. If you have had any other operation please list them:
Approximate year:_________ Type of Surgery:_____________________________________
Approximate year:_________ Type of Surgery:_____________________________________
Approximate year:_________ Type of Surgery:_____________________________________
Approximate year:_________ Type of Surgery:_____________________________________
69. Please list any other hospitalizations:
Approximate year:_________ Reason:____
Approximate year:_________ Reason:____
Approximate year:_________ Reason:____
Approximate year:_________ Reason:____
70. Please list any other diagnosis we should be aware of:__________________________________
____
71. Give a representative blood pressure:________________
72. What are your average temperatures (oral – 11AM to 7PM) Degrees:_____________________

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Diagnosis:

73. Have you previously been diagnosed with Fibromyalgia or Chronic Fatigue Syndrome?
❑ Yes ❑ No

If so, please list all medications taken in the **past** for Fibromyalgia and/or Chronic Fatigue Syndrome (no longer taking): Please fill in what you can remember.

Medication	Dose	When was the medication discontinued?	Did the medication help?	Single main reason it was discontinued?
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps

74. Any injected or intravenous treatments? ❑ Yes ❑ No

If so, please fill in the corresponding boxes the best you can.

Treatment	How many total treatments?	Did the treatment help?	Main reason stopped?
		❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
		❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
		❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps

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75. Have you ever taken nutritional supplements to assist your diagnosis? ❑ Yes ❑ No

Please list nutritional supplements taken in the **past** (not currently taking).

Supplement	Dose	When was the supplement discontinued?	Did the supplement help?	Single main reason it was discontinued?
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps
			❒ Helps ❒ Doesn't help ❒ Don't know if it helps	❒ Side effects ❒ Didn't work ❒ Don't know if it helps

76. Are there any other treatments not already mentioned taken in the past that made you feel worse? Please Explain:____

77. Do you have severe chronic fatigue of six months or longer duration with other known medical conditions excluded by clinical diagnosis? ❑ Yes ❑ No

78. Concurrently have four or more of the following symptoms:

❑ Impairment in short-term memory or concentration severe enough to cause substantial reduction in previous levels of personal activity
❑ Sore throat
❑ Tender neck or axillary (armpit) lymph nodes
❑ Muscle pain
❑ Multi-joint pain without joint swelling or redness
❑ Headaches of a new type, pattern, or severity
❑ Un-refreshing sleep
❑ Post-exertion fatigue lasting more than 24 hours

If yes, how many consecutive months did these symptoms prevail?:____________

Did these symptoms occur prior to fatigue?:_______________________________

79. Please list any chemicals, foods, or molds you are allergic or sensitive to:________________
____
____
____

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(Fibromyalgia Criteria)

80. Have you had chronic widespread pain for more than three months in all four quadrants of the body (i.e., above and below the waist and on both sides of the body) and also axial pain (i.e., headache or pain around the spine or chest)? ❑ Yes ❑ No

81. How is your energy? ❑ Very poor ❑ Slight ❑ Moderate ❑ Good ❑ Excellent
82. How is your sleep? ❑ Very poor ❑ Slight ❑ Moderate ❑ Good ❑ Excellent
83. How is your mental clarity? ❑ Very poor ❑ Slight ❑ Moderate ❑ Good ❑ Excellent
84. How bad is your achiness? ❑ Very poor ❑ Slight ❑ Moderate ❑ Good ❑ Excellent
85. Your overall sense of well-being: ❑ Very poor ❑ Slight ❑ Moderate ❑ Good ❑ Excellent

86. Has any antibiotic you've been on in the past even temporarily improved your Chronic Fatigue/ Fibromyalgia Symptoms? ❑ Yes ❑ No
    If so, which?:____
    ____
    How long did you take it?:____
    ____

Other Hormones

87. ❑ Any nipple discharge
    If so, was it from?: ❑ One breast ❑ Both breasts

Vasodepressor Syncope (NMH)

88. ❑ Disequilibrium
89. ❑ Have taken a Tilt Table Test
    If so, was it: ❑ Positive ❑ Normal
90. ❑ Do you feel like you've been "hit by a truck" the day after exercise?

Lyme

91. ❑ Have had a tick bite before
    ❑ History of frequent tick bites How many?:________
    ❑ Rash after tick bite
    ❑ Rash that looked like a "bull's eye"
    ❑ Have you been treated for Lyme disease
    ❑ Numbness or tingling in your fingers or feet
    ❑ History of a positive Lyme Test

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Sinusitis/Nasal Congestion & Other Infections

92. ❑ Chronic nasal congestion or post nasal drip
93. ❑ Chronic yellow or green nasal discharge
94. ❑ Chronic bad taste in your mouth or bad breath
95. ❑ Headaches under or over eyes
96. ❑ Scratchy/watery eyes

97. ❑ You have chronic or intermittent low-grade fevers (over 99 degrees F/ or Celsius)
    If so, How high does the fever go?:____________
    ❑ Your illness began with a fever
    ❑ You have lung congestion
    How often do you have the fever?:________________________________

Disordered Sleep

98. ❑ Trouble falling and/or ❑ Staying asleep
    If so, is it: ❑ Mild Problem ❑ Moderate Problem ❑ Severe problem
99. How many hours of uninterrupted sleep do you get a night?:_________
100. ❑ You wake up during the night
    If so, how often?:_________________________________
101. ❑ You wake at night to urinate
102. ❑ Your legs jump a lot, or kick your spouse or blankets off at night
103. ❑ You snore
    If so, Are you more than 20lbs overweight? ❑ Yes ❑ No
    Do you have periods that you stop breathing (ask your bed partner)? ❑ Yes ❑ No
    Do you have high blood pressure? ❑ Yes ❑ No

Yeast Overgrowth

104. ❑ Toenail or fingernail fungal changes
105. ❑ Skin fungal infections (i.e., athlete's foot, jock itch, rash under bra)
106. ❑ You get in the mouth sores frequently (not on lips)?
107. ❑ You get cold sores or Herpes attacks that seem to flare your symptoms, or during symptom flares
108. ❑ Small amounts of alcohol aggravate symptoms

Parasites

109. ❑ Your problems began with a diarrhea attack
110. ❑ You sometimes have diarrhea If so, is it severe?: ❑ Yes ❑ No
111. ❑ You sometimes have constipation
112. ❑ You drink well water

Vision/Dental

113. ❑ Double vision
114. ❑ Constantly changing eyeglass prescriptions
115. ❑ Blurred vision or halos around lights at night

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116. ❑ Have had temporary vision loss in one eye
If so, which one?: ❑ Left ❑ Right ❑ Both
How many times?:______________________________
How long do they last?:__________________________
Is your sedimentation (sed) rate blood test over 30?:
❑ Yes ❑ No ❑ Don't know
117. ❑ Dry eyes
118. ❑ Dry mouth
119. ❑ Any evidence of dental infections
120. ❑ Metallic taste in mouth
121. ❑ Light sensitivity or trouble focusing at night

Other Problems and Questions

122. ❑ Ringing ears
123. ❑ Hearing loss
124. ❑ You have frequent and persistent infections
If so, what kind?:____
❑ You get a rash
If so, what does it look like?:____
How long have you had it?:____
The rash: ❑ Itches ❑ Burns ❑ Stings
125. ❑ Chest pain
If so, how long have you had it?:____
Has it been getting ❑ Better ❑ Worse ❑ Staying the same
With exercise like walking does the pain:
❑ Increase ❑ Decrease ❑ Stay the same
With exercise do you have:
❑ Shortness of breath ❑ Chest tightness
❑ Pain radiating to your left arm ❑ Heavy sweating
Can you worsen the same chest pain by pushing on your chest muscles?:
❑ Yes ❑ No
Are the chest pains any of the following with position change or deep breath?:
❑ Sharp ❑ Dull ❑ Worse
During the chest pains do you have any of the following?:
❑ Feeling of being unable to take a deep enough breath
❑ Numbness and/or tingling in hands and toes
❑ Numbness and/or tingling around the mouth
❑ Feeling light headed
❑ Feeling of panic or impending death
Did your father, mother, sister(s), or brother(s) have angina?: ❑ Yes ❑ No
If so, did they have it before age 65?: ❑ Yes ❑ No
126. ❑ You have high cholesterol
If so, approximately how high?:____
127. ❑ You have Diabetes
128. ❑ You have high blood pressure

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129. ❑ Recurrent palpitations
If so, check all that apply:
❑ Palpitations last over 20 seconds ❑ Regular pulse ❑ Irregular pulse
❑ Pulse over 120/minute ❑ Taking Thyroid hormones

130. ❑ Shortness of breath
If so, check all that apply:
❑ Comes and goes suddenly (not with exercise)
❑ Wake up short of breath at night?
If so, check all that apply:
❑ You have ankle swelling
❑ You get short of breath if you lay flat
If so, how many pillows do you sleep on?:_______________
❑ Worse with exertion?
How many flights of steps before you are short of breath?:________

131. ❑ Transient weakness/paralysis in one arm or leg
If so, is it always on the same side of your body?: ❑ Yes ❑ No
If so, which side?: ❑ Left ❑ Right
Does it occur in your arm when you're sleeping on it and it goes away within 5 minutes of waking?: ❑ Yes ❑ No
If **NO**, how many times has it occurred?:______________________
How long does it last?:______________________________________

132. ❑ Ankle swelling

133. ❑ Any unusual or unintended weight loss
If so, please fill in following information.
How many lbs/kg?:_______________ Over how many years?:___________
When did this happen?:____________ Please describe what happened:_____
____

134. ❑ Numbness or tingling around your lips or mouth

135. ❑ Anxiety or panic attacks

136. ❑ Sudden attacks of inability to take a deep enough breath or shortness of breath

137. ❑ Blood in your stool
If so, is it only bright red blood on your toilet tissue or on stool (not mixed in):
❑ Yes ❑ No
If so, do you have hemorrhoids? ❑ Yes ❑ No
If **NO**, check all that apply:
❑ The blood is mixed in (not only on) your stool
❑ You have bloody mucus with stools How often?:_______________
❑ You have painful bowel movements
Please check any of the following that you have had performed
❑ A Colonoscopy ❑ A Sigmoidoscopy ❑ A Barium Enema ❑ None
If any of the above, please provide the estimated time when it occurred, the result and diagnoses the best of your knowledge:___________________________
____
If any of the above, have your bowel movements gotten thinner (e.g., pencil like)?:____
Have you had a lot of: ❑ Constipation ❑ Diarrhea

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138. ❑ Abdominal pains If so, please describe?:______________________________

139. ❑ Cough up blood If so, how long has it been going on?:______________________

❑ Have had a chest x-ray since this began? If so, when?:____________

What did it show?:____

140. ❑ Frequently cough up yellow mucus

❑ Have you had a chest x-ray since this began If so, when?:____________

What did it show?:____

141. ❑ Chronic cough If so, for how long?:_________________________________

❑ Have had a chest x-ray since this began If so, when?:________________

What did it show?:____

142. ❑ Pain in your feet

143. ❑ Pain in your hands

144. ❑ Chronic anal/rectal pain

145. ❑ Redness and swelling in one or more joints in hands or feet

If so, please select all that apply:

❑ In left hand ❑ In right hand ❑ In left foot ❑ In right foot?

If any, check all that you have a history of:

❑ Gout ❑ Rheumatoid Arthritis

Other Arthritis:_______________________________________

146. ❑ Any breast lump that you have had for more than 6 weeks

If so, which breast: ❑ Right Breast ❑ Left Breast

❑ Nipple discharge

If so, please check all that apply to the discharge:

❑ Milky ❑ Pus ❑ Bloody ❑ Clear

❑ Right breast ❑ Left breast

How long have you had it?:________________________________

147. ❑ Have had problems with infertility

If so, do you still want to have a (or another) child?: ❑ Yes ❑ No

148. ❑ Food often sticks in your food pipe How long has this been going on?:________

____

If so, is it worse for any of the following?

❑ Solids ❑ Liquids ❑ Same for both

❑ You have a history of drinking over 2 alcoholic drinks/day on average

❑ You have used tobacco for over 12 years

149. ❑ Your tongue burns

If so, check all that apply:

❑ Your tongue become smooth with cracks/fissures

❑ You have a white coating throughout your mouth

❑ You have a white coating on your tongue

❑ Small taste buds sometimes become inflamed and painful

150. ❑ History of psychiatric illness Please describe:____________________

____

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151. Please describe any other symptom(s) or problem(s). Please understand that it's important for you to list them all:____

____

____

152. Did you have/need to change jobs or decrease how much you work because of your illness?: ❑ Yes ❑ No Please describe:____

____

153. Did your symptoms begin soon or immediately after any of the following?:

❑ Pregnancy ❑ After an accident

If either, how soon?:____

If accident, please give details of the accident:____

____

If accident, please check all that apply:

Since the accident, have the symptoms?:

❑ Decreased ❑ Increased ❑ Stayed the same

154. Do you feel depressed (as opposed to frustrated over not being able to function)?:

❑ Yes ❑ No

Hormones:

Symptom List:
(Cortisol Checklist) Some symptoms are purposely repeated.
Check all that apply:

155. ❑ Hypoglycemia
156. ❑ Shakiness relieved with eating
157. ❑ Moodiness
158. ❑ Recurrent infections that take a long time to go away
159. ❑ Life was very stressful before symptoms began
160. ❑ Low blood pressure
161. ❑ Dizziness on first standing
162. ❑ Sugar cravings
163. ❑ Food Sensitivity
164. ❑ Have been on Prednisone (Cortisone)

If so, for how long?:____

What dose & form of cortisone/ Prednisone did you take?:______________________

❑ You felt better when you took it

If so, did you take it:

❑ After your illness began ❑ Before illness began ❑ Both

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Do you have or feel the following symptoms?

Poor Tolerance to Stress	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Anxiety with Stress	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Low Blood Pressure	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Tired During the day	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Fatigue or mood improved with Sugar of sweets	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Salt Cravings	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Nausea	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Inflammatory disease (arthritis, asthma. Etc.)	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Allergies to food or medications	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Brown spots or increased pigmentation	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Eczema, Psoriasis or dandruff	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Sugar cravings	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

(Aldosterone Checklist)

Weak or tired when standing up	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Urinate often	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Low blood pressure	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

(Thyroid Checklist)

165. ❑ Weight gain If so, lbs:________________ kg:_______________
Over how many years:_____________________________________
166. ❑ Low body temperature (under 98 degrees)
167. ❑ Achiness
168. ❑ High cholesterol
169. ❑ Cold intolerance
170. ❑ Dry skin
171. ❑ Thin hair
172. ❑ Heavy periods

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Do you have or feel the following symptoms?

Symptom					
Sensitive to cold	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Cold hands or feet	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Generalized fatigue	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Morning fatigue	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Fatigue unless exercising	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Sleepy during the day	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Distracted easily	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Poor motivation for required tasks	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Depression	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Headaches	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Water retention	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Constant swollen eyelids	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Swollen eyes in morning	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Swollen calves/feet	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Difficulty losing weight despite dieting	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Constipation	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Bedwetting as child	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Slow heart palpitations	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Muscle cramps	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Carpal tunnel syndrome	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Stiff joints in morning	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Joint pain worsens with cold	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Hoarse voice in morning	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Dry skin (general/feet or elbows)	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Slow growing or brittle nails	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Diffuse hair loss	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Muscle achiness or soreness	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Low body temperature	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Diminished sweating	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Tingling or numbness in extremities	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Hoarse voice	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Decreased hearing	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Coarse skin (rough skin)	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

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(Growth Hormone Checklist)

Thinning hair	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Thinning skin	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Longitudinal lines on nails	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Premature wrinkling on face	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Loose or sagging skin	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Thinning lips	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Overweight	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Decreased muscle strength or tone	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Flabby muscles (triceps of arm or other)	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Wrinkled hands	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Flabby drooping belly	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Often sick	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Easily exhausted	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Difficult to do daily required tasks	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Poor motivation for required tasks	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Constant tiredness	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Difficult to stay up late	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Difficult to recover after staying up late	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Need for a lot of sleep (over 10 hours)	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Low resistance to stress	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Difficult to recover after stressful situation	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Not assertive	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Very emotional	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Mood swings	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Anxiety	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Low self-esteem	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Depression	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Thin muscles as child	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Tendency to isolate	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Tend to give sharp verbal retorts	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

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(Melatonin Checklist)

Poor sleep	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Difficulty falling asleep	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Awakening at night	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Excessive pondering of problems at night	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Waking up tired (too little sleep)	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Yeast Questionnaire:
Section A.

173. ❑ (50 points) Have you been treated for acne with tetracycline, erythromycin, or any other antibiotic for one month or longer?
174. ❑ (50 points) Have you taken antibiotics for any type of infection for more than two consecutive months, or in shorter courses four or more times in a twelve-month period?
175. ❑ (6 points) Have you ever taken an antibiotic – even for a single course?
176. ❑ (25 points) Have you ever had prostates, vaginitis, or another infection or problem with your reproductive organs for more than one month?
177. Have you ever been pregnant:
    - ❑ (5 points) Two or more times
    - ❑ (3 points) Once
178. Have you taken birth control pills for:
    - ❑ (15 points) more than two years
    - ❑ (8 points) six months to two years
179. You take corticosteroids such as prednisone, Cortef, or Medrol by mouth or inhaler for:
    - ❑ (15 points) More than two weeks
    - ❑ (6 points) Two weeks or less
180. When you are exposed to perfumes, insecticides, or other odors or chemicals, do you develop wheezing, burning eyes, or any other distress?
    - ❑ (20 points) Yes, and the symptoms keep me from continuing my activities
    - ❑ (5 points) Yes, but the symptoms are mild and do not change my activities
    - ❑ (0 points) No
    - ❑ (20 points) Are your symptoms worse on damp or humid days or in moldy places?
181. Have you ever had a fungal infection, such as jock itch, athlete's foot, or a nail or skin infection, that was difficult to treat and:
    - ❑ (20 points) Lasted for more than two months
    - ❑ (10 points) Lasted less than two months
182. Do you crave:
    - ❑ (10 points) Sugar
    - ❑ (10 points) Breads
    - ❑ (10 points) Alcoholic beverages
    - ❑ (10 points) Does tobacco smoke cause you discomfort such as wheezing, burning eyes, or other problems?

For office use:

_______ Total Score of Section A

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Section B: Major Symptoms

Please check one for each of the following symptoms:

Fatigue or lethargy	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Feeling of being "drained"	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Poor memory	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Feeling "spacey" or "unreal"	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Inability to make decisions	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Numbness, burning, or tingling	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Insomnia	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Muscle aches	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Muscle weakness or paralysis	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Pain and/or swelling in joins	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Abdominal pain	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Constipation	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Diarrhea	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Bloating, belching or intestinal gas	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Troublesome vaginal burning, itching, or discharge	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Prostatitis	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Impotence	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Loss of sexual desire or feeling	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Endometriosis or infertility	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Cramps and/or other Menstrual irregularities	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Premenstrual tension	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Attacks of anxiety or crying	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Cold hands or feet and/or chilliness	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Shaking or irritable when hungry	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
For office use:	_____ x 3 points=______	_____ x 6 points=_______	_____ x 9 points=_______
For office use:			Section B Total:________

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Section C: Other Symptoms

Please check one for each of the following symptoms:

Drowsiness	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Irritability or jitteriness	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Lack of coordination	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Inability to concentrate	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Frequent mood swings	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Dizziness, loss of balance	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Pressure above ears, feeling of head swelling	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Tendency to bruise easily	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Chronic rashes or itching	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Psoriasis or recurrent hives	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Indigestion or heartburn	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Food sensitivity or intolerance	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Mucus in stools	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Rectal itching	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Dry mouth or throat	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Rash or blisters in mouth	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Bad breath	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Foot, hair, or body odor not relieved by washing	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Nasal congestion or postnasal drip	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Nasal itching	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Sore throat	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Laryngitis, loss of voice	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Cough or recurrent bronchitis	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Pain or tightness in chest	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Wheezing or shortness of breath	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling

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Urinary frequency, urgency, or incontinence	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Burning on urination	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Spots in front of eyes or erratic vision	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Burning or tearing of eyes	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Recurrent infections or fluid in ears	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
Ear pain or deafness	❑ None, occasional, mild	❑ Frequent and/or moderately severe	❑ Severe and/or Disabling
For office use:	_____ x 1 points=_____	____ x 2 points=______	____ x 3 points=______
For office use:			Section C Total:_______

For office use:	Grand Total (A,B & C):_________

(Estrogen Checklist)

Do you have or feel the following symptoms?

Older looking than age	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Loss of attention to details	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Bleeding gums or poor teeth	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Fatigue throughout day	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Poor recovery from physical exercise	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Depressed	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Poor memory	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Hot flashes	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Excessive sweating	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Dry eyes	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Dry vagina	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Pain during intercourse	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Pale skin	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Wrinkles around eyes/forehead/mouth or palm	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
New body hair	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

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Drooping breasts	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Bladder infections	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Urinary incontinence	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
First menstruation before 12 or after 15 years	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Depression before menstruation	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Day or night sweats or hot flashes	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

(Progesterone checklist)

Do you have or ever had the following symptoms?

Irritable before menstruation (PMS)	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Swollen breast or belly before menstruation	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Breast cysts	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Fibroids of uterus	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Endometriosis	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Menstruation with violent cramps	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
General irritability	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
General anxiety	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

(Testosterone Checklist)

Do you have or feel the following symptoms?

Too emotional	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Too rigid	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Poor strength	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Low libido (sex drive)	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

Difficulty achieving orgasm	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Poor muscle tone	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Excessive fat	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Cellulite	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Varicose veins	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Hemorrhoids	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always
Bruising easily	❑ Never	❑ Sometimes	❑ Regularly	❑ Often	❑ Always

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❑ You have had a hysterectomy
If so, how long ago?:___________________

183. ❑ Ovaries removed
If so, ❑ One ❑ Both How long ago:___________________________________

184. ❑ A tubal legation If so, how long ago?:_____________________________________

185. ❑ Your symptoms worse the week before your period?

186. ❑ Decreased libido

187. ❑ Recurrent vaginal yeast infections
If so, how often?:______________________

188. ❑ Been on birth control pills?
If so, how did you feel taking them: ❑ Better ❑ Worse ❑ No change

189. ❑ Chronic burning when you urinate and urinary urgency even with small volumes
If so, have you had urine cultures checked? ❑ Yes ❑ No
Do they usually show infection? ❑ Yes ❑ No
Is this a severe problem? ❑ Yes ❑ No

190. ❑ You are currently breastfeeding
If so, do you have any other lumps or bumps that are new or growing?
❑ Yes ❑ No Please describe:_____________________________________
____

191. How many days ago was your last period?:_______

The End

phone: (469) 909-9907