

Excellent Good Fair Poor

How would you describe your general state of health

How motivated are you to improve your health? (Zero motivation to very motivated) 0 ● ● ● ● ● ● ● ●

What are your goals for today?

Goal 1

Goal 2

Goal 3

What expectations do you have from this visit?

What long term expectations do you have from your ongoing care at Wellness Architecture NSI

What expectations do you have of me as your doctor?

What potential obstacles do you see in making changes in your lifestyle and following directions necessary to support your health?

New Patient Office Policy

Wellness Architecture Naturopathic Services Inc. (WANSI) is a cash office and payment is expected at time of service. Payment methods include check (preferable), Visa, Mastercard, or cash. If you have an insurance policy that will reimburse you for naturopathic medicine visits we will provide you with a superbill with appropriate diagnostic and billing codes that you can submit to the insurance company for reimbursement of your visit. We suggest that you make a copy of the superbill prior to submission because of consistent insurance clerical error. Our office will not interact with insurance companies on your behalf.

Cancellation Policy

We have a 48 hour cancellation/reschedule policy. If you do not call our offices 48 hours prior to your scheduled appointment, you will be charged a 100% of the late cancellation/missed appointment fee.

We require a credit card number for our records to schedule your first appointment. Your credit card will not be charged unless you do not provide adequate cancellation notice and will be kept on file for missed appointments or appointments with inadequate cancellation notice.

By signing below, I agree that I have read and understood the policy. I guarantee payment of all charges incurred as a patient of WANSI.

Signed: _____ Date: _____

Printed Name: _____ Date: _____

Parent or Guardian (minor): _____ Date: _____

Notice of Privacy Practices

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family member and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to WANSI 841 El Camino Real, Menlo Park, CA.

Note: We must respond to this request within 30 days.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to WANSI 841 El Camino Real, Menlo Park, CA.

Note: We must respond within 60 days. The Privacy Officer or the patient's doctor will usually do this. If the doctor believes the information is complete and accurate, the doctor can refuse to make any changes.

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Samia McCully at WANSI. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Dr. Samia McCully at WANSI.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that Wellness Architecture Naturopathic Services Inc. has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact:

Dr. Samia McCully
650-233-7327

I also understand that I am entitled to receive updates upon request if WANSI amends or changes its Notice of Privacy Practices in a material way.

Signature

Relationship to Patient, if signed by someone other than patient.

Date

THIS SECTION IS TO BE COMPLETED BY WELLNESS ARCHITECTURE SERVICES INC. IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

- Patient declined to sign this Written Acknowledgment.
- Other (specify): _____

Name and title of employee

Date

INFORMED CONSENT FOR TREATMENT

I, _____, hereby authorize Dr. Samia McCully Natur-opathic doctor of Wellness Architecture Naturopathic Services Inc. to perform the following specific pro-cedures as necessary to facilitate my diagnosis and treatment:

Common diagnostic procedures: e.g., venipuncture, radiography, laboratory, x-ray.

Minor office procedures: e.g., dressing a wound, ear cleansing.

Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation, and intramuscular vitamin injections.

Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, creams, plasters, or suppositories.

Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.

Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

Psychological Counseling

I recognize the potential risks and benefits of these procedures as described below:

Potential risks: allergic reactions to prescribed herbs and supplements, side effects of natural medications, inconvenience of lifestyle changes, injury from injections, venipuncture or procedures.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant as some of the therapies used could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Wild Women Wellness or any of its personnel regarding cure or improvement of my condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my medical record will be kept for a minimum of three, but no more than ten years after the date of my last visit.

Date

Signature of Patient

Signature of Patient Representative or Guardian

Health History Questionnaire

Please take the time to fill out this questionnaire carefully. If you have any questions, ask for assistance. If you have concerns that are not listed, make note of them in the comments section. The completed form will greatly assist us in providing a thorough evaluation of your health.

Confidential Patient Profile

Name: _____ Age: _____ Date of Birth: _____ Sex: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone: Home () _____ Work () _____ Cell () _____
E-mail: _____

Occupation: _____ How did you hear about us? _____

Emergency Contact: _____ Relationship: _____ Day Phone: () _____

Chief Complaint: In this section please list in order of importance your health concerns.

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

Current Medication List: In this section please list all pharmaceutical medication(s) that you are currently taking along with dosage and frequency

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

Are you allergic to any medications? YES NO

If "Yes", please list: _____

What happens when you have an allergic attack to medication? _____

Have you ever been treated with antibiotics? YES NO How many times: _____

Hospitalizations: Include reason, year and duration: _____

Current Supplement List: In this section please include all homeopathics, herbs, vitamins, minerals you are currently taking with dosage.

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

Social History

Do you or have you used any of the following:	Never	Past	Daily	Weekly
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreational Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee or black tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Energy drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laxative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet Pills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soda/Sugary drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you currently: Married Divorced Single Long-Term Relationship Widowed

Number of children and ages? _____

Have you traveled outside the US in the past year? Yes _____ No ____ If yes, where? _____

With whom do you live? (including roommates, friends, partner, spouse, children, parents, relatives, pets)

Relationship	Age	Relationship	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What are the major stressors in your life? _____

What to you do to relax/relieve stress? _____

What interests/hobbies do you have? _____

Describe your energy level on a scale of 1-10 (10 high energy): Morning _____ Afternoon: _____ Evening: _____

Describe your sleep pattern (e.g., restful, interrupted etc.): _____

Nutrition

How many meals do you generally eat per day? _____ Do you skip meals? _____ How many servings of fruit per day? _____

How many servings of vegetables do you consume each day? (Svg: 1C raw, 1/2 C cooked) _____

Are you currently on a special diet? Foods you avoid? Please explain. _____

How would you describe your relationship with food? What motivates you to eat or not? _____

How often do you eat out? _____ Who prepares meals at home? _____

Family History

Indicate if a close relative (parent, child, sibling, grandparent) has had any of the following & indicate which member:

	NO	YES	Member
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma/allergies/hives	<input type="checkbox"/>	<input type="checkbox"/>	
Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>	
Depression/suicide	<input type="checkbox"/>	<input type="checkbox"/>	
Other mental illness	<input type="checkbox"/>	<input type="checkbox"/>	
Drug/Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple Sclerosis (MS) or Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>	
Autoimmune condition	<input type="checkbox"/>	<input type="checkbox"/>	
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal Diseases	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	
Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	

Review of Systems

Mental/Emotional	Currently	Past	Never	Neurological	Currently	Past	Never
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Easily stressed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety/nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo/dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consider or attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin/Hair/Nails			
Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rashes/Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PTSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Moles/growths/warts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine				Athletes foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypo/hyperthyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Color changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia/Low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head			
Increased thirst	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaw problems/TMJ	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spots in eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overweight or Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impaired vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Near/Farsighted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurriness/hallows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain/strain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tearing/dryness/redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Review of Systems

Ears	Currently	Past	Never	Lungs	Currently	Past	Never
Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ringing/buzzing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear aches/pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess ear wax	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose	Currently	Past	Never	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever/rhinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of smell	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mouth/Throat	Currently	Past	Never	Pain on breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular	Currently	Past	Never
Chronic sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Teeth grinding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Silver fillings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hoarse voice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental cavities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Root canals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of sense of taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neck	Currently	Past	Never	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations/fluttering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Review of Systems

Gastrointestinal

Currently Past Never

Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Mucous in Stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Belching/Flatulence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loose stools/Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice (yellow skin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver or gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Black stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travelers Diarrhea/Parasites	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Urinary

Currently Past Never

Pain on urinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increased frequency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inability to hold urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urgency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urination at night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal

Currently Past Never

Joint pain/stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Currently Past Never

Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Spasm/weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Peripheral Vascular

Cold hands & feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deep leg pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thrombophlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy bleeding/bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Female

Currently Past Never

PCOS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian Cysts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibroids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Length of Cycle ____ Length of Menses ____

Age of First Menses: _____

Cycles are Regular YES NO

HIV Positive YES NO

Breakthrough Bleeding YES NO

Acne YES NO

Menstrual Cramps YES NO

Breast Tenderness YES NO

Mood Changes YES NO

Bloating YES NO

Sexual orientation: _____

Date of last PAP & physical exam: _____

Children: _____ # Pregnancies: _____

Miscarriages: _____ # Abortions: _____