FIVE STONES

Integrative Functional Medicine

GENERAL INFORMATION

Name	First Middle		Last	
Preferred Name				
Date of Birth				
Age				
Gender	Male	Female		
Genetic Background	African Asian	European Ashkenazi	Native American Middle Eastern	Mediterranean _____
Job Title				
Nature of Business				
Primary Address	Number, Street			Apt. #
	City		State	Zip
Alternate Address	Number, Street			Apt. #
	City		State	Zip
Home Phone 1				
Home Phone 2				
Work Phone				
Cell Phone				
Fax				
E-mail				
Emergency Contact 1	Name		Phone Number	
Relationship			Cell Number	
	Address		Work Number	
	City		State	Zip
Emergency Contact 2	Name		Phone Number	
Relationship			Cell Number	
	Address		Work Number	
	City		State	Zip

Primary Care Physician

Name Phone

Fax

Referred by Book Website Friend or Family Member

Other _____

PHARMACY INFORMATION

Primary Pharmacy

Name Phone

Address

City State Zip

E-mail **Fax***

* It is extremely important that you list the pharmacy's fax number

Compounding/ Supplement Pharmacy

Name Phone

Address

City State Zip

E-mail **Fax***

* It is extremely important that you list the pharmacy's fax number

Medical Questionnaire

ALLERGIES

Medication/Supplement/Food	Reaction

COMPLAINTS CONCERNS

What do you hope to achieve in your visit with us? _____

_____

If you had a magic wand and could erase three problems, what would they be?

1. _____

2. _____

3._____ When was the last time you felt well? _____

_____ Did something trigger your change in health? _____

_____ What makes you feel worse? _____

_____ What makes you feel better? _____

_____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success: Excellent	Good	Fair
Example: Post Nasal Drip		X		Elimination Diet	X		

MEDICAL HISTORY

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

GASTROINTESTINAL

- ☐ ☐ Irritable Bowel Syndrome_____
- ☐ ☐ Inflammatory Bowel Disease _____
- ☐ ☐ Crohn's _____
- ☐ ☐ Ulcerative Colitis _____
- ☐ ☐ Gastritis or Peptic Ulcer Disease _____
- ☐ ☐ GERD (reflux) _____
- ☐ ☐ Celiac Disease _____
- ☐ ☐ Other _____

CARDIOVASCULAR

- ☐ ☐ Heart Attack _____
- ☐ ☐ Other Heart Disease _____
- ☐ ☐ Stroke _____
- ☐ ☐ Elevated Cholesterol _____
- ☐ ☐ Arrythmia (irregular heart beat) _____
- ☐ ☐ Hypertension (High Blood Pressure) _____
- ☐ ☐ Rheumatic Fever _____
- ☐ ☐ Mitral Valve Prolapse _____
- ☐ ☐ Other _____

METABOLIC/ENDOCRINE

- ☐ ☐ Type 1 Diabetes _____
- ☐ ☐ Type 2 Diabetes _____
- ☐ ☐ Hypoglycemia _____
- ☐ ☐ Metabolic Syndrome _____
- ☐ ☐ Hypothyroidism _____
- ☐ ☐ Hyperthyroidism _____
- ☐ ☐ Endocrine Problems _____
- ☐ ☐ Polycystic Ovarian Syndrome _____
- ☐ ☐ Infertility _____
- ☐ ☐ Weight Gain _____
- ☐ ☐ Weight Loss _____
- ☐ ☐ Frequent Weight Fluctuations _____
- ☐ ☐ Bulimia _____
- ☐ ☐ Anorexia _____
- ☐ ☐ Binge Eating Disorder _____
- ☐ ☐ Eating Disorder (non-specific) _____
- ☐ ☐ Other _____

CANCER

- ☐ ☐ Lung Cancer _____
- ☐ ☐ Breast Cancer _____
- ☐ ☐ Colon Cancer _____
- ☐ ☐ Ovarian Cancer _____
- ☐ ☐ Prostate Cancer _____
- ☐ ☐ Skin Cancer _____
- ☐ ☐ Other _____

☐ = Past Condition

☐ = Ongoing Condition

GENITAL AND URINARY SYSTEMS

- ☐ ☐ Kidney Stones _____
- ☐ ☐ Other _____

MUSCULOSKELETAL/PAIN

- ☐ ☐ Osteoarthritis _____
- ☐ ☐ Fibromyalgia _____
- ☐ ☐ Chronic Pain _____
- ☐ ☐ Other _____

INFLAMMATORY/AUTOIMMUNE

- ☐ ☐ Chronic Fatigue Syndrome _____
- ☐ ☐ Autoimmune Disease _____
- ☐ ☐ Rheumatoid Arthritis _____
- ☐ ☐ Lupus SLE _____
- ☐ ☐ Immune Deficiency Disease _____
- ☐ ☐ Herpes-Genital _____
- ☐ ☐ Severe Infectious Disease _____
- ☐ ☐ Poor Immune Function _____
- ☐ ☐ Food Allergies _____
- ☐ ☐ Environmental Allergies _____
- ☐ ☐ Multiple Chemical Sensitivities _____
- ☐ ☐ Latex Allergy _____
- ☐ ☐ Other _____

RESPIRATORY DISEASES

- ☐ ☐ Asthma _____
- ☐ ☐ Chronic Sinusistis _____
- ☐ ☐ Bronchitis _____
- ☐ ☐ Emphysema _____
- ☐ ☐ Pneumonia _____
- ☐ ☐ Tuberculosis _____
- ☐ ☐ Sleep Apnea _____
- ☐ ☐ Other _____

SKIN DISEASES

- ☐ ☐ Eczema _____
- ☐ ☐ Psoriasis _____
- ☐ ☐ Acne _____
- ☐ ☐ Melanoma _____
- ☐ ☐ Skin Cancer _____
- ☐ ☐ Other _____

MEDICAL HISTORY (CONTINUED)

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

NEUROLOGIC/MOOD

- ☐ ☐ Depression _____
- ☐ ☐ Anxiety _____
- ☐ ☐ Bipolar Disorder _____

☐ ☐ Schizophrenia _____
☐ ☐ Headaches _____
☐ ☐ Migraines _____
☐ ☐ ADD/ADHD _____

PREVENTITIVE TESTS AND DATE OF LAST TEST

☐ Full Physical Exam _____
☐ Bone Density _____
☐ Colonoscopy_____
☐ Cardiac Stress Test _____
☐ EBT Heart Scan _____
☐ EKG _____
☐ Hemoccult Test-stoll test for blood _____
☐ MRI _____
☐ CT Scan _____
☐ Upper Endoscopy _____
☐ Upper GI Series _____
☐ Ultrasound _____

INJURIES *(Check box if yes)*

☐ Back Injury _____
☐ Neck Injury _____
☐ Head Injury _____
☐ Broken Bones _____
☐ Other _____

HOSPITALIZATIONS ☐ None

Date	Reason

□ = Ongoing Conditions

☐ ☐ Autism _____
☐ ☐ Mild Cognitive Impairment _____
☐ ☐ Memory Problems _____
☐ ☐ Parkinson's Disease _____
☐ ☐ Multiple Sclerosis _____
☐ ☐ ALS _____
☐ ☐ Seizures _____
☐ ☐ Other Neurological Problems _____

SURGERIES *(Check box if yes and provide date of surgery)*

☐ ☐ Appendectomy _____
☐ ☐ Hysterectomy +/- Ovaries _____
☐ ☐ Gall Bladder _____
☐ ☐ Hernia _____
☐ ☐ Tonsillectomy _____
☐ ☐ Dental Surgery _____
☐ ☐ Joint Replacement- Knee/Hip _____
☐ ☐ Heart Surgery-Bypass Valve _____
☐ ☐ Angioplasty or Stent _____
☐ ☐ Pacemaker _____
☐ ☐ Other _____
☐ ☐ None _____

BLOOD TYPE:

○A ○B ○AB ○0 ○Rh+ ○unknown

COMMENTS

_____
_____
_____
_____

□ = Past Condition

GYNECOLOGIC HISTORY (for women only)

OBSTETRIC HISTORY Check box if yes and provide number of

Pregnancies _____ Caesarean _____ Vaginal deliveries _____

Miscarriage _____ Abortion _____ Living Children_____

Post Partum Depression Toxemia Gestational Diabetes Baby Over 8 Pounds

Breast Feeding For how long? _____

MENSTRUAL HISTORY

Age at First Period:_____ Menses Frequency:_____ Length:_____ Pain: Yes No Clotting: Yes No

Has your period ever skipped?_____ For how long?_____

Last Menstrual Period:_____

Use of hormonal contraception such as: Birth Control Pills Patch Nuva Ring How long?_____

Do you use contraception? Yes No Condom Diaphragm IUD Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

Fibrocystic Breasts Endometriosis Fibroids Infertility

Painful Periods Heavy periods PMS

Last Mammogram:_____ Breast Biopsy/Date:_____

Last PAP Test:_____ Normal Abnormal

Last Bone Density:_____ Results: High Low Within Normal Range

Are you in menopause? Yes No

Age at Menopause_____

Hot Flashes Mood Swings Concentration/Memory Problems Vaginal Dryness Decreased Libido

Heavy Bleeding Joint Pains Headaches Weight Gain Loss of Control of Urine Palpitations

Use of hormone replacement therapy. How long?_____

MEN'S HISTORY (for men only)

Have you had a PSA done? Yes No

PSA Level: 0-2 2-4 4-10 >10

Prostate Enlargement Prostate infection Change in Libido Impotence

Difficulty Obtaining an Erection Difficulty Maintaining an Erection

Nocturia (urination at night). How many times at night? _____

Urgency/Hesitancy/Change in Urinary Stream ___ Loss of Control of Urine ___

GI HISTORY

Foreign Travel Yes No Where? _____

Wilderness Camping? Yes No Where? _____

Have you ever had severe: Gastroenteritis Diarrhea

Do you feel like you digest your food well? Yes No

Do you feel bloated after meals? Yes No

PATIENT BIRTH HISTORY

Term ___ Premature ___

Pregnancy Complications: _____ Birth

Complications: _____

Breast Fed. How long?_____ Bottle Fed ___

Age at introduction of: Solid Foods:_____ Dairy:_____ Wheat:_____

Did you eat a lot of candy or sugar as a child? Yes No

DENTAL HISTORY

DENTAL SURGERY

Silver Mercury Fillings How many? _____

Gold Fillings Root Canals Implants Tooth Pain Bleeding Gums

Gingivitis Problems with Chewing

Do you floss regularly? Yes No

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS Last 10 years

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplication & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? Yes No

Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? Yes No

Have you had prolonged or regular use of Tylenol? Yes No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)? Yes No

Frequent antibiotics > 3 times/year? Yes No

Long-term antibiotics? Yes No

Use of steroids (prednisone, nasal allergy inhalers) in the past? Yes No

Use of oral contraceptives? Yes No

FAMILY HISTORY

Check Family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? Yes No

Have you made any changes in your eating habits because of your health? Yes No Describe: _____

Do you currently follow a special diet or nutritional program? Yes No

Circle all that apply:

Low Fat Low Carbohydrate High Protein Low Sodium Diabetic No Dairy No Wheat

Gluten Restricted Vegetarian Vegan Ultrametabolism

Specific Program for Weight Loss/Maintenance Type: _____ Other_____

Height (feet/inches)_____	Current Weight _____
Usual Weight Range +/- 5 lbs _____	Desired Weight Range +/- 5 lbs_____
Highest Adult Weight _____	Lowest Adult Weight_____
Weight Fluctuations (> 10 lbs) Yes No	Body Fat % _____

How often do you weigh yourself? Daily Weekly Monthly Rarely Never

Have you ever had your metabolism (resting metabolic rate) checked? Yes No If yes, what was it? _____

Do you avoid any particular foods? Yes No If yes, types and reason _____

_____ If you could only eat a few foods a week, what would they be?_____

_____ Do you grocery shop? Yes No If no, who does the shopping? _____

Do you read food labels? Yes No _____

Do you cook? Yes No If no, who does the cooking? _____

How many meals do you eat out per week? 0-1 1-3 3-5 >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

- ☐ Fast eater
- ☐ Erratic eating pattern
- ☐ Eat too much
- ☐ Late night eating
- ☐ Dislike healthy food
- ☐ Time constraints
- ☐ Eat more than 50% meals away from home
- ☐ Travel frequently
- ☐ Non-availability of healthy foods
- ☐ Do not plan meals or menus
- ☐ Reliance on convenience items
- ☐ Poor snack choices
- ☐ Significant other or family members don't like healthy foods
- ☐ Significant other or family members have special dietary needs or food preferences
- ☐ Eat because I have to
- ☐ Have a negative relationship to food
- ☐ Struggle with eating issues
- ☐ Emotional eater (eat when sad, lonely, depressed, bored)
- ☐ Eat too little under stress
- ☐ Eat too much under stress
- ☐ Love to eat
- ☐ Don't care to cook
- ☐ Eating in the middle of the night
- ☐ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is:

_____

SMOKING

Currently Smoking? Yes No How many years? _____ Packs per day: _____

Attempts to quit: _____

Previous Smoking: How many years? _____ Packs per day? _____

Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits

None 1-3 4-6 7-10 > 10 If "None," skip to Other Substances

Previous alcohol intake? Yes (Mild Moderate High) None

Have you ever been told you should cut down your alcohol intake? Yes No

Do you get annoyed when people ask you about your drinking? Yes No

Do you ever feel guilty about your alcohol consumption? Yes No

Do you ever take an eye-opener? Yes No

Do you notice a tolerance to alcohol (can you "hold" more than others)? Yes No

Have you ever been unable to remember what you did during a drinking episode? Yes No

Do you get into arguments or physical fights when you have been drinking? Yes No

Have you ever been arrested or hospitalized because of drinking? Yes No

Have you ever thought about getting help to control or stop your drinking? Yes No

OTHER SUBSTANCES

Caffeine Intake: Yes No | Coffee cups/day: 1 2-4 > 4 | Tea cups/day: 1 2-4 >4

Caffeinated Sodas or Diet Sodas Intake: Yes No

12-ounce can/bottle 1 2-4 > 4 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.): _____

Are you currently using any recreational drugs? Yes No Type _____

Have you ever used IV or inhaled recreational drugs? Yes No

EXERCISE

Current Exercise Program: (List type of activity, number of sessions/week, and duration)

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? Low Medium High

List problems that limit activity: _____

_____

Do you feel unusually fatigued after exercise? Yes No

If yes, please describe: _____

_____

Do you usually sweat when exercising? Yes No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? Yes No

Are you happy? Yes No

Do you feel your life has meaning and purpose? Yes No

Do you believe stress is presently reducing the quality of your life? Yes No

Do you like the work you do? Yes No

Have you ever experienced major losses in your life? Yes No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? Yes No

Would you describe your experience as a child in your family as happy and secure? Yes No

STRESS/COPING

Have you ever sought counseling? Yes No

Are you currently in therapy? Yes No Describe: _____

Do you feel you have an excessive amount of stress in your life? Yes No

Do you feel you can easily handle the stress in your life? Yes No

Daily Stressors: Rate on scale of 1-10

Work _____ Family _____ Social _____ Finances_____ Health_____ Other_____

Do you practice meditation or relaxation techniques? Yes No How often? _____

Check all that apply: Yoga Meditation Imagery Breathing Tai Chi Prayer Other: _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes No

SLEEP/REST

Average number of hours you sleep per night: >10 8-10 6-8 <6

Do you have trouble falling asleep? Yes No

Do you feel rested upon awakening? Yes No

Do you have problems with insomnia? Yes No

Do you snore? Yes No

Do you use sleeping aids? Yes No Explain: _____

ROLES/RELATIONSHIP

Marital status Single Married Divorced Gay/Lesbian Long Term Partnership Widow

List Children: Child's Full Name	Age	Gender

Who is living in Household? Number:_____ Names: _____

Their Employment/Occupations: _____

Resources for emotional support?

Circle all that apply: Spouse Family Friends Religious/Spiritual Pets Other: _____

Are you satisfied with your sex life? Yes No

How well have things been going for you?	Very Well	Fine	Poorly	N/A
Overall				
At school				
In your job				
In your social life With close				
friends				
With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children with your				
parents With your spouse				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? Yes No If yes, describe symptoms:

_____

Do you have any food allergies or sensitivities? Yes No List all:_____ Do you have an adverse reaction to caffeine? Yes No

When you drink caffeine do you feel: Irritable or Wired Aches & Pains

Do you adversely react to (Check all that apply):

Monosodium glutamate (MSG) Aspartame (Nutrasweet) Caffeine Bananas Garlic Onion

Cheese Citrus Foods Chocolate Alcohol Red Wine

Sulfite Containing Foods (wine, dried fruit, salad bars) Preservatives (ex. sodium benzoate)

Other: _____

Which of these significantly affect you? Check all that apply:

Cigarette Smoke Perfumes/Colognes Auto Exhaust Fumes Other: _____

In your work or home environment, are you exposed to: Chemicals Electromagnetic Radiation Mold

Have you ever turned yellow (jaundiced)? Yes No

Have you ever been told you have Gilbert's syndrome or a liver disorder? Yes No

Explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

Herbicides Insecticides (frequent visits of exterminator) Pesticides Organic Solvents

Heavy Metals Other _____

Chemical Name, Date, Length of Exposure: _____

Do you dry clean your clothes frequently? Yes No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? Yes No

Do you have any pets or farm animals? Yes No

SYMPTOM REVIEW

Please circle all current symptoms occurring or present in the past 6 months.

GENERAL

- Cold Hands & Feet
- Cold Intolerance
- Low Body Temperature
- Low Blood Pressure
- Daytime Sleepiness
- Difficulty Falling Asleep
- Early Waking
- Fatigue
- Fever
- Flushing
- Heat Intolerance
- Night Waking
- Nightmares
- No Dream Recall

HEAD, EYES & EARS

- Conjunctivitis
- Distorted Sense of Smell
- Distorted Taste
- Ear Fullness
- Ear Pain
- Ear Ringing/Buzzing
- Lid Margin Redness
- Eye Crusting
- Eye Pain
- Hearing Loss
- Hearing Problems
- Headache
- Migraine
- Sensitivity to Loud Noises
- Vision problems (other than glasses)
- Macular Degeneration
- Vitreous Detachment
- Retinal Detachment

MUSCULOSKELETAL

- Back Muscle Spasm
- Calf Cramps
- Chest Tightness
- Foot Cramps
- Joint Deformity
- Joint Pain
- Joint Redness
- Joint Stiffness
- Muscle Pain
- Muscle Spasms
- Muscle Stiffness
- Muscle Twitches:
  - Around Eyes
  - Arms or Legs
- Muscle Weakness
- Neck Muscle Spasm
- Tendonitis
- Tension Headache
- TMJ Problems

MOOD/NERVES

- Agoraphobia
- Anxiety
- Auditory Hallucinations
- Black-out
- Depression
- Difficulty:
  - Concentrating
  - With Balance
  - With Thinking
  - With Judgment
  - With Speech
  - With Memory
- Dizziness (Spinning)
- Fainting
- Fearfulness
- Irritability
- Light-headedness
- Numbness
- Other Phobias
- Panic Attacks
- Paranoia
- Seizures
- Suicidal Thoughts
- Tingling
- Tremor/Trembling
- Visual Hallucinations

EATING

- Binge Eating
- Bulimia
- Can't Gain Weight Can't
- Lose Weight
- Can't Maintain Healthy Weight
- Frequent Dieting
- Poor Appetite Salt
- Cravings
- Carbohydrate Craving (breads, pastas)
- Sweet Cravings (candy, cookies, cakes)
- Chocolate Cravings
- Caffeine Dependency

DIGESTION

- Anal Spasms
- Bad Teeth
- Bleeding Gums
- Bloating of:
  - Lower Abdomen
  - Whole Abdomen
  - Bloating After Meals
- Blood in Stools
- Burping
- Canker Sores
- Cold Sores
- Constipation
- Cracking at Corner of Lips
- Cramps
- Dentures w/Poor Chewing
- Diarrhea
- Alternating Diarrhea and Constipation
- Difficulty Swallowing
- Dry Mouth
- Excess Flatulence/Gas
- Fissures
- Foods "Repeat" (Reflux)
- Gas
- Heartburn
- Hemorrhoids
- Indigestion
- Nausea
- Upper Abdominal Pain
- Vomiting
- Intolerance to:
  - Lactose
  - All Dairy Products
  - Wheat
  - Gluten (Wheat, Rye, Barley)
  - Corn
  - Eggs
  - Fatty Foods
  - Yeast
- Liver Disease/Jaundice (Yellow Eyes or Skin)
- Abnormal Liver Function Tests
- Lower Abdominal Pain
- Mucus in Stools
- Periodontal Disease
- Sore Tongue
- Strong Stool Odor
- Undigested Food in Stools

SKIN PROBLEMS

- Acne on Back
- Acne on Chest
- Acne on Face
- Acne on Shoulders
- Athlete's Foot
- Bumps on Back of Upper Arms
- Cellulite
- Dark Circles Under Eyes
- Ears Get Red
- Easy Bruising
- Lack Of Sweating
- Eczema
- Hives
- Jock Itch
- Lackluster Skin
- Moles w/Color/Size Change
- Oily Skin
- Pale Skin
- Patchy Dullness
- Rash
- Red Face
- Sensitivity to Bites
- Sensitivity to Poison Ivy/Oak
- Shingles
- Skin Darkening
- Strong Body Odor
- Hair Loss
- Vitiligo

ITCHING SKIN

- Skin in General
- Anus
- Arms
- Ear Canals
- Eyes
- Feet
- Hands
- Legs
- Nipples
- Nose
- Penis
- Roof of Mouth
- Scalp
- Throat

SKIN, DRYNESS OF

- Eyes
- Feet
    - Any Cracking?
    - Any Peeling?
- Hair
    - And Unmanageable?
- Hands
    - Any Cracking?
    - Any Peeling?
- Mouth/Throat
- Scalp
    - Any Dandruff?
- Skin In General

LYMPH NODES

- Enlarged/neck
- Tender/neck
- Other Enlarged/Tender
- Lymph Nodes

NAILS

- Bitten
- Brittle
- Curve Up
- Frayed
- Fungus-Fingers
- Fungus-Toes
- Pitting
- Ragged Cuticles
- Ridges
- Soft or Thickening of:
- Fingernails
- Toenails
- White Spots/Lines

RESPIRATORY

- Bad Breath
- Bad Odor in Nose
- Cough-Dry
- Cough-Productive
- Hoarseness
- Sore Throat
- Hay Fever:
    - Spring
    - Summer
    - Fall
    - Change Of Season
- Nasal Stuffiness
- Nose Bleeds
- Post Nasal Drip
- Sinus Fullness
- Sinus Infection
- Snoring
- Wheezing
- Winter Stuffiness

CARDIOVASCULAR

- Angina/chest pain
- Breathlessness
- Heart Murmur
- Irregular Pulse
- Palpitations
- Phlebitis
- Swollen Ankles/Feet
- Varicose Veins

URINARY

- Bed Wetting
- Hesitancy (trouble getting started)
- Infection
- Kidney Disease
- Leaking/Incontinence
- Pain/Burning
- Prostate Infection
- Urgency

MALE REPRODUCTIVE

- Discharge From Penis
- Ejaculation Problem
- Genital Pain
- Impotence
- Prostate or Urinary Infection
- Lumps In Testicles
- Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

- Breast Cysts
- Breast Lumps
- Breast Tenderness
- Ovarian Cyst
- Poor Libido (Sex Drive)
- Vaginal Discharge
- Vaginal Odor
- Vaginal Itch
- Vaginal Pain with Sex
- Premenstrual:
    - Bloating Breast Tenderness
    - Carbohydrate Cravings
    - Chocolate Cravings
    - Constipation
    - Decreased Sleep
    - Diarrhea
    - Fatigue
    - Increased Sleep
    - Irritability

Menstrual:

- Cramps
- Heavy Periods
- Irregular Periods
- No Periods
- Scanty Periods
- Spotting Between