LEXINGTON NATURAL HEALTH CENTER

Name: _____ Date:_____

Review of Symptoms

Please complete this questionnaire as thoroughly as possible. This is a confidential record of your medical history and will not be released except when you have authorized us to do so.

Please check Y = Yes, N = No

General
Y N
☐ ☐Fatigue
☐ ☐Night Sweats

Skin
Y N
☐ ☐Infections
☐ ☐Growths
☐ ☐Rashes/Inflammation
☐ ☐Changes in hair or nails

Head
Y N
☐ ☐Headaches
☐ ☐Dizziness

Eyes
Y N
☐ ☐Eye pain
☐ ☐Impaired Vision ☐ Glasses ☐ Contacts
☐ ☐Excessive tearing
☐ ☐Excessive dryness

Ears
Y N
☐ ☐Ringing
☐ ☐Earaches
☐ ☐Itching

Nose
Y N
☐ ☐Chronic Nose Bleeds
☐ ☐Chronic Stuffiness
☐ ☐Chronic Sinus Problems
☐ ☐Chronic Post Nasal Drip

Mouth & Throat
Y N
☐ ☐Frequent Sore Throat
☐ ☐Sores in Mouth
☐ ☐Sores on Lips
☐ ☐Gum or Dental Problems

Neck
Y N
☐ ☐Chronic Pain or Stiffness
☐ ☐Chronic Swollen Glands

Blood
Y N
☐ ☐Have you ever been diagnosed with anemia?

Respiratory
Y N
☐ ☐Chronic Cough
☐ ☐Shortness of Breath
☐ ☐Wheezing
☐ ☐Positive TB Test ever?
☐ ☐Cough up blood ever?

Heart/Circulation
Y N
☐ ☐Chest pain or Tightness
☐ ☐Palpitations, Fluttering
☐ ☐Varicose Veins
☐ ☐Swelling of Ankles
☐ ☐Cold Hands/Feet
☐ ☐Deep Leg Pain
☐ ☐Heart Murmer
☐ ☐Ever diagnosed with Rheumatic Fever?

Digestion
Y N
☐ ☐Heartburn
☐ ☐Stomach pain
☐ ☐Chronic Nausea
☐ ☐Chronic unexplained Vomiting
☐ ☐Daily Bowel Movements
☐ ☐Blood in Bowel Movement
☐ ☐Mucus in Bowel Movement
☐ ☐Chronic Belching
☐ ☐Chronic Gas
☐ ☐Hemorrhoids

Urinary
Y N
☐ ☐Pain on urination
☐ ☐Increased Frequency
☐ ☐Inability to hold urine
☐ ☐Chronic bladder infections

Please Continue on Other Side

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Female Reproduction:

Age menses began _____
No. of days of Menstrual Flow _____
Length of Complete Cycle _____
Date of Last Menstrual Period _____

Y N

☐ ☐Are your Cycles Regular?
☐ ☐Bleeding in between periods?
☐ ☐Midcycle pain
☐ ☐Cramps with your period
☐ ☐Excessive Menstrual flow
☐ ☐PMS Symptoms

Y N

☐ ☐Bloating/Swelling
☐ ☐Irritability/Anger
☐ ☐Depression
☐ ☐Anxiety

Y N ☐ ☐Excessive Hunger
☐ ☐Pain during intercourse
☐ ☐Ever suffer from any Venereal Diseases?
Which one(s): _____
☐ ☐ Ever been pregnant?

No. of Pregnancies _____
No. of Live Births _____
No. of Miscarriages _____
No. of Abortions _____

☐ ☐ Birth control?
What type? _____
☐ ☐Menopausal signs/symptoms

Y N

☐ ☐Hot flashes
☐ ☐Night Sweats
☐ ☐Insomnia
☐ ☐Heart palpitations
☐ ☐Urinary Dysfunction
☐ ☐Changes in Sex Drive
☐ ☐Hair loss
☐ ☐Facial Hair
☐ ☐Acne
☐ ☐Vaginal dryness

Breasts

Y N

☐ ☐Do you do self exam regularly
☐ ☐Lumps
☐ ☐Pain or tenderness
☐ ☐Nipple discharge

Male Reproduction

Y N

☐ ☐Testicular masses
☐ ☐Testicular pain
☐ ☐Ever any prostate problems
☐ ☐Abnormal discharge or sores of penis
☐ ☐Veneral Disease
Which one(s): _____
☐ ☐Sexual Difficulties
☐ ☐Difficulty starting and stopping urine
☐ ☐Birth control
What type? _____

Neurological

Y N

☐ ☐History of Fainting
☐ ☐History of Seizures
☐ ☐Numbness or Tingling

Musculoskeletal

Y N

☐ ☐Joint pain or stiffness
☐ ☐Muscle spasms or cramps
☐ ☐Muscle weakness
☐ ☐Hernias

Endocrine

Y N

☐ ☐Ever any thyroid problem
☐ ☐Heat or cold intolerance
☐ ☐Excessive thirst
☐ ☐Excessive hunger
☐ ☐Easy weight gain