



PATIENT SYMPTOM SURVEY

DATE _____

PATIENT'S NAME _____ AGE _____

WEIGHT _____ HEIGHT _____ BLOOD PRESSURE _____ PULSE _____ O₂ _____

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time...

Primary Complaints

- | | | |
|--|--|--|
| 090 <input type="checkbox"/> General Good Health | 039 <input type="checkbox"/> High Blood Pressure 401.9 | 063 <input type="checkbox"/> Prostate Disorder 602.9 |
| 091 <input type="checkbox"/> Desires Nutritional & Metabolic Analysis | 040 <input type="checkbox"/> Low Blood Pressure 458.9 | 069 <input type="checkbox"/> Hyperthyroidism 242.90 |
| 001 <input type="checkbox"/> Skin Disorder 692.9 | 041 <input type="checkbox"/> Tachycardia (High Heart Rate) 785.00 | 070 <input type="checkbox"/> Hypothyroidism 244.9 |
| 002 <input type="checkbox"/> Acne 706.1 | 042 <input type="checkbox"/> Numbness 782.0 | 071 <input type="checkbox"/> Systemic Lupus 710.0 |
| 003 <input type="checkbox"/> Psoriasis 696.1 | 043 <input type="checkbox"/> Constipation 564.0 | 072 <input type="checkbox"/> Infertility, female 628.9 |
| 004 <input type="checkbox"/> Urticaria (Hives) 708.9 | 044 <input type="checkbox"/> Indigestion 536.8 | 073 <input type="checkbox"/> Interstitial Cystitis 595.1 |
| 005 <input type="checkbox"/> ADD/ADHD 314.00/314.01 | 045 <input type="checkbox"/> Ulcerative Colitis 556.9 | 074 <input type="checkbox"/> Irregular Menstrual Cycle 626.4 |
| 006 <input type="checkbox"/> Allergies, Unspecified 477.9 | 046 <input type="checkbox"/> Depression 311 | 075 <input type="checkbox"/> Menopausal Symptoms 627.2 |
| 007 <input type="checkbox"/> Allergic Rhinitis from food 477.1 | 047 <input type="checkbox"/> Diabetes Mellitus 250.0 | 076 <input type="checkbox"/> Hot Flashes 627.2 |
| 008 <input type="checkbox"/> Sinusitis 461.9 | 030 <input type="checkbox"/> Diabetes Type I 250.01 | 077 <input type="checkbox"/> Mental Disorder 300.9 |
| 009 <input type="checkbox"/> Alzheimer's 331.0 | 031 <input type="checkbox"/> Diabetes Type II 250.02 | 078 <input type="checkbox"/> Insomnia 780.52 |
| 010 <input type="checkbox"/> Poor Concentration/Memory 310.1 | 029 <input type="checkbox"/> Hyperglycemia [high blood sugar] 790.29 | 079 <input type="checkbox"/> Mouth/Throat/Tongue |
| 011 <input type="checkbox"/> Parkinson's Disease 332.0 | 048 <input type="checkbox"/> Hypoglycemia [low blood sugar] 251.2 | 080 <input type="checkbox"/> Canker Sores 528.2 |
| 012 <input type="checkbox"/> Anemia 285.9 | 049 <input type="checkbox"/> Dizziness/Balance Problem 780.4 | 081 <input type="checkbox"/> Overweight 278.02 |
| 013 <input type="checkbox"/> Arthritic Disorder 716.90 | 050 <input type="checkbox"/> Ear Infection 381.4 | 082 <input type="checkbox"/> Underweight 783.22 |
| 014 <input type="checkbox"/> Osteoporosis 733.00 | 051 <input type="checkbox"/> Epstein Barr 075 | 083 <input type="checkbox"/> Sexual Disorder 302.89 |
| 015 <input type="checkbox"/> Asthma 493.90 | 052 <input type="checkbox"/> Eye Problems 379.91 | 084 <input type="checkbox"/> Spinal Problems 724.9 |
| 016 <input type="checkbox"/> Emphysema 492.8 | 053 <input type="checkbox"/> Cataracts 366.9 | 085 <input type="checkbox"/> Obesity 278.00 |
| 017 <input type="checkbox"/> Cancer | 054 <input type="checkbox"/> Glaucoma 365.9 | 086 <input type="checkbox"/> GERD 530.81 |
| 018 <input type="checkbox"/> Breast 174.9female 175.9male | 055 <input type="checkbox"/> Macular Degeneration 362.50 | 087 <input type="checkbox"/> HIV 042 |
| 019 <input type="checkbox"/> Prostate 185 | 056 <input type="checkbox"/> Fever 780.6 | 088 <input type="checkbox"/> Crohn's Disease 555.9 |
| 020 <input type="checkbox"/> Lung 162.9 | 057 <input type="checkbox"/> Fibromyalgia 729.1 | 089 <input type="checkbox"/> Irritable Bowel Syndrome 564.1 |
| 021 <input type="checkbox"/> Colon and Rectal 153.9 | 058 <input type="checkbox"/> Gallbladder Disorder 575.9 | 092 <input type="checkbox"/> Normal Pregnancy v22.2 |
| 022 <input type="checkbox"/> Skin 173.9 | 059 <input type="checkbox"/> Gout 274.9 | **only applicable if currently pregnant |
| 023 <input type="checkbox"/> Leukemia w/o remission 208.90
Leukemia w/ remission 208.91 | 060 <input type="checkbox"/> Headaches 784.0 | 093 <input type="checkbox"/> Shingles 053.9 |
| 024 <input type="checkbox"/> Lymphoma, malignant 202.8 | 061 <input type="checkbox"/> Hearing Loss 389.9 | 140 <input type="checkbox"/> Migraines 346.90 |
| 025 <input type="checkbox"/> Brain Tumor, malignant 191.9 | 062 <input type="checkbox"/> Infertility, male 606.9 | 141 <input type="checkbox"/> Rheumatoid Arthritis 714.0 |
| 027 <input type="checkbox"/> Anxiety Disorder 300.00 | 064 <input type="checkbox"/> Liver Disease 571.9 | 142 <input type="checkbox"/> Non-Systemic Lupus 695.4 |
| 028 <input type="checkbox"/> Autism 299.00 | 065 <input type="checkbox"/> Hepatitis 573.3 | 143 <input type="checkbox"/> Multiple Sclerosis 340 |
| 033 <input type="checkbox"/> Edema 782.3 | 066 <input type="checkbox"/> Hepatitis B 070.30 | 144 <input type="checkbox"/> ALS (Lou Gehrig's) 335.20 |
| 034 <input type="checkbox"/> Eczema 692.9 | 067 <input type="checkbox"/> Hepatitis C 070.51 | 145 <input type="checkbox"/> Polymyalgia Rheumatica 725 |
| 035 <input type="checkbox"/> Chronic Fatigue 780.71 | 068 <input type="checkbox"/> Kidney Disorder 593.9 or Bladder Disorder 596.9 | 146 <input type="checkbox"/> Scleroderma 710.1 |
| 036 <input type="checkbox"/> Circulatory Disorder 459.9 | | 171 <input type="checkbox"/> Goiter 240.9 |
| 037 <input type="checkbox"/> Heart Disease 429.9 | | 178 <input type="checkbox"/> Raynaud's Syndrome 443.8 |
| 038 <input type="checkbox"/> High Cholesterol 272.0 | | 179 <input type="checkbox"/> Hemochromatosis 275.0 |
| | | 180 <input type="checkbox"/> Thalassemia 282.49 |
| | | 181 <input type="checkbox"/> Brain aneurysm 431 |

If necessary, please state your most significant concern...

General Health

- 100 ☐ Fingernail base is pink
101 ☐ Fingernail base is purple
102 ☐ Fingernails have ridges or white spots
103 ☐ Fingernails are soft
104 ☐ Fingernails are splitting
105 ☐ Fingernails peel
106 ☐ Pale fingernail beds
107 ☐ Blacks out easily
108 ☐ Balance problems
109 ☐ Difficulty walking
110 ☐ Has tattoos
111 ☐ Brittle hair
112 ☐ Dry hair
113 ☐ Thin hair
114 ☐ Hair loss
115 ☐ Drinks alcoholic beverages daily
116 ☐ Drinks less than 8 glasses of water per day
117 ☐ Currently on Chemotherapy
118 ☐ Currently on radiation treatment
119 ☐ Had chemotherapy in the past
120 ☐ Has had radiation treatments in the past
121 ☐ Gained over 20 lbs in the last 12 months
122 ☐ Somewhat Overweight
123 ☐ Somewhat Underweight
- 124 ☐ Unexplained loss of >20lbs in last 4 months
125 ☐ Energy level is worse than it was 5 years ago
127 ☐ Sleeps less than 6 hours per night
128 ☐ Unable to recall dreams the next day
129 ☐ Sensitive to chemicals, paint, fumes, cologne
130 ☐ Had blood transfusion in the past
131 ☐ Had transplant in the past
138 ☐ Takes anti-rejection drugs
132 ☐ Had a major accident or injury
137 ☐ Sleep Apnea
139 ☐ Toxic chemical exposure
175 ☐ Has been out of the country recently
176 ☐ Had childhood vaccines
177 ☐ Had a vaccine in the last 12 months
147 ☐ Had a flu shot last year
182 ☐ Had a pneumonia vaccine last year
183 ☐ Had a Hepatitis B vaccine in the last 2 years.
- Has a family history of:
- 184 ☐ Cancer
185 ☐ Heart Disease
186 ☐ Diabetes
187 ☐ Alcoholism
188 ☐ Depression
189 ☐ Obesity

Lifestyle & Environment

- Do you use? ☐ Well Water ☐ City Water Filtered? ☐ Yes ☐ No Filter Type? _____
What kind of pipes are in your home? ☐ Steel ☐ CPVC ☐ Copper ☐ Pex ☐ Other _____
What year was your home built? _____ Any renovations in the past year? _____
Do you use chlorine bleach or other heavy duty cleaners in your home/work? ☐ Yes ☐ No
Have you ever worked around heavy machinery, plumbing, automotive or the metallurgic industry? ☐ Yes ☐ No
Explain: _____
Have you ever worked around industrial solvents, chemicals or pesticides? ☐ Yes ☐ No
Explain: _____

- 380 ☐ Drinks beverages from a can
370 ☐ Drinks alcohol
371 ☐ Drinks caffeinated coffee
372 ☐ Drinks caffeinated pop/soda
373 ☐ Drinks caffeinated tea
374 ☐ Drinks decaffeinated coffee
375 ☐ Drinks decaffeinated pop/soda
376 ☐ Drinks decaffeinated tea
377 ☐ Drinks >3 cups of coffee daily
378 ☐ Drinks >3 cups of tea per day
388 ☐ Drinks diet pop/soda
- 379 ☐ Drinks >1 pop/sodas per day
I had 4 alcoholic drinks in one day:
172 ☐ never
173 ☐ more than 3 months ago
174 ☐ less than 3 months ago
381 ☐ Has >5 alcoholic drinks/week
391 ☐ Craves sugar / starches
382 ☐ Currently smokes
383 ☐ Quit smoking in last 5 years
384 ☐ Smoked for >5 years
385 ☐ Smokes >1 pack per day
- 126 ☐ Rarely exercises
133 ☐ Regularly exercises
386 ☐ Takes Vitamins
134 ☐ Vegetarian
135 ☐ Eats no red meat
136 ☐ Eats no meat, no dairy
387 ☐ Frequent use of artificial sweeteners
389 ☐ Anorexia
390 ☐ Bulimic

Surgeries

- 700 ☐ Tonsillectomy and/or Adenoids
- 701 ☐ Appendix
- 702 ☐ Gallbladder
- 703 ☐ Thyroid
- 704 ☐ Hysterectomy, complete
- 705 ☐ Hysterectomy, partial
- 706 ☐ Tubal ligation

- 707 ☐ Breast implants
- 708 ☐ Cancer
- 709 ☐ Coronary by-pass
- 710 ☐ Spinal surgery
- 711 ☐ Extremity surgery
- 712 ☐ Hip replacement
- 713 ☐ Knee replacement

- 714 ☐ Splenectomy
 - 715 ☐ Radiated thyroid
 - 716 ☐ Cataract surgery
 - 717 ☐ Hemorrhoidectomy
 - 718 ☐ Bariatric/Weight loss
- Type: _____

Gastrointestinal

- 265 ☐ 4-5 bowel movements per week
- 266 ☐ 3 or less bowel movements per week
- 267 ☐ 6 or more bowel movements per week
- 268 ☐ Black tarry stools
- 269 ☐ Pale or yellow colored stool
- 270 ☐ Blood stools
- 271 ☐ Constipation
- 272 ☐ Hemorrhoids
- 273 ☐ Loose bowel movements
- 274 ☐ Frequent diarrhea
- 275 ☐ Frequent nausea
- 276 ☐ Frequent vomiting
- 277 ☐ Abdominal gas
- 278 ☐ Belching and burping after eating
- 279 ☐ Bloating after eating
- 280 ☐ Severe abdominal pains
- 281 ☐ Stomach ulcers
- 282 ☐ Uses digestive aids
- 283 ☐ Uses laxatives

- 284 ☐ Immediate indigestion upon eating
- 285 ☐ Indigestion in 2 hours or more after meals
- 286 ☐ Indigestion within 1 hour after meals
- 287 ☐ Difficulty swallowing
- 288 ☐ Eating relieves fatigue
- 289 ☐ Eats when nervous
- 290 ☐ Excessive hunger
- 291 ☐ Poor appetite
- 292 ☐ Experiences fainting spells when hungry
- 293 ☐ Feels shaky when hungry
- 294 ☐ Frequently drowsy after eating a meal
- 295 ☐ Gall bladder disease
- 296 ☐ Has had intestinal worms
- 297 ☐ Reflux/Hiatal hernia
- 298 ☐ Liver disease
- 299 ☐ Irritable Bowel Syndrome
- 300 ☐ Diverticulitis
- 301 ☐ Diverticulosis

Respiratory

- 485 ☐ Catches severe colds
- 486 ☐ Chronic chest condition
- 487 ☐ Chronic cough
- 488 ☐ Constant runny nose
- 489 ☐ COPD
- 490 ☐ Difficulty breathing

- 491 ☐ Frequent colds
- 492 ☐ Frequent nose bleeds
- 493 ☐ Frequent sinus infections
- 494 ☐ Frequent stuffy nose
- 495 ☐ Hay fever
- 496 ☐ Nasal polyps

- 497 ☐ Night sweats
- 498 ☐ Post nasal drip
- 499 ☐ Sneezing spells
- 500 ☐ Spits up blood
- 501 ☐ Spits up phlegm
- 502 ☐ Wheezes

Mouth and Throat

- 400 ☐ Bad breath
- 401 ☐ Bitter taste in the mouth
in the morning
- 402 ☐ Dry mouth
- 403 ☐ Excessive saliva
- 404 ☐ Sores or cracks in the
corners of the mouth
- 405 ☐ Glands often swell
- 406 ☐ Frequent canker sores

- 407 ☐ Frequent fever blisters
- 408 ☐ Frequent sore throats
- 409 ☐ Frequently has a sore
tongue
- 410 ☐ Sore gums
- 411 ☐ Swollen gums
- 412 ☐ Swollen tongue
- 413 ☐ Tongue burns

- 414 ☐ Tongue has grooves or fissures
- 415 ☐ Tongue is coated
- 416 ☐ Gums bleed when brushing teeth
- 417 ☐ Toothaches
- 418 ☐ Amalgam dental fillings
- 420 ☐ Other dental fillings
(gold, composite, etc)
- 419 ☐ Has had root canal(s)

Endocrine

- | | | |
|---|---|---|
| 245 <input type="checkbox"/> Coarse hair | 249 <input type="checkbox"/> Frequently feels cold | 253 <input type="checkbox"/> Unusually jumpy or nervous |
| 246 <input type="checkbox"/> Coarse skin | 250 <input type="checkbox"/> Frequently feels hot | 254 <input type="checkbox"/> Unusually tired most of the time |
| 247 <input type="checkbox"/> Diabetic | 251 <input type="checkbox"/> Gets lightheaded when standing quickly | |
| 248 <input type="checkbox"/> Excessive thirst | 252 <input type="checkbox"/> Heals slowly | |

Cardiovascular

- | | |
|--|--|
| 190 <input type="checkbox"/> Cold feet | 198 <input type="checkbox"/> Pain in leg/hips when walking |
| 191 <input type="checkbox"/> Cold hands | 199 <input type="checkbox"/> Frequent swollen ankles |
| 192 <input type="checkbox"/> Experiences shortness of breath while sitting still | 200 <input type="checkbox"/> Pains in the heart or chest |
| 193 <input type="checkbox"/> Heart skips beats | 201 <input type="checkbox"/> Spells of rapid heart rate |
| 194 <input type="checkbox"/> Tendency of High blood pressure | 202 <input type="checkbox"/> Troubled with blood clots |
| 195 <input type="checkbox"/> Leg cramps during bedtime | 203 <input type="checkbox"/> Unusually slow pulse rate |
| 196 <input type="checkbox"/> Leg cramps during daytime | 204 <input type="checkbox"/> Varicose veins |
| 197 <input type="checkbox"/> Low blood pressure at times | 205 <input type="checkbox"/> Heart palpitations |

Skin

- | | | |
|---|--|---|
| 520 <input type="checkbox"/> Bruises easily | 526 <input type="checkbox"/> Itchy skin | 529 <input type="checkbox"/> Skin eruptions |
| 521 <input type="checkbox"/> Excessive perspiration | 527 <input type="checkbox"/> Problems with Eczema | 531 <input type="checkbox"/> Skin is tender |
| 522 <input type="checkbox"/> Frequent goose bumps | 528 <input type="checkbox"/> Has moles which are changing in size and/or color | 532 <input type="checkbox"/> Sores that heal slowly |
| 523 <input type="checkbox"/> Has acne | 530 <input type="checkbox"/> Skin is rough, especially on the back of the arms | 533 <input type="checkbox"/> Troubled with boils |
| 524 <input type="checkbox"/> Has Psoriasis | | 534 <input type="checkbox"/> Dry skin |
| 525 <input type="checkbox"/> Hives | | |

Ears

- | | | |
|--|--|--|
| 220 <input type="checkbox"/> Discharge from ears | 222 <input type="checkbox"/> Punctured ear drum | 224 <input type="checkbox"/> Ringing or noises in the ears |
| 221 <input type="checkbox"/> Hard of hearing | 223 <input type="checkbox"/> Recurrent ear infection | 225 <input type="checkbox"/> Tinnitus |

Eyes

- | | | |
|---|---|--|
| 320 <input type="checkbox"/> Bloodshot eyes | 325 <input type="checkbox"/> Eyes watery | 329 <input type="checkbox"/> Mild Macular degeneration |
| 321 <input type="checkbox"/> Blurred vision | 326 <input type="checkbox"/> Mild Glaucoma | 330 <input type="checkbox"/> Itchy eyes |
| 322 <input type="checkbox"/> Cross eyes | 327 <input type="checkbox"/> Far sighted | 331 <input type="checkbox"/> Near sighted |
| 323 <input type="checkbox"/> Eye pain | 328 <input type="checkbox"/> Developing cataracts | 332 <input type="checkbox"/> Dry Eyes |
| 324 <input type="checkbox"/> Eyes feel gritty | | |

Feet

- | | | |
|---|--|---|
| 350 <input type="checkbox"/> Corns | 353 <input type="checkbox"/> Painful feet | 355 <input type="checkbox"/> Swelling in the feet and/or ankles |
| 351 <input type="checkbox"/> Frequent foot cramps | 354 <input type="checkbox"/> Plantar warts | 356 <input type="checkbox"/> Plantar fasciitis |
| 352 <input type="checkbox"/> Heel spurs | | 357 <input type="checkbox"/> Fungal Infection |

Neuromuscular

- | | | |
|---|---|--|
| 440 <input type="checkbox"/> Bites nails | 449 <input type="checkbox"/> Has motion sickness | 457 <input type="checkbox"/> Low back pain |
| 441 <input type="checkbox"/> Frequent muscle soreness | 450 <input type="checkbox"/> Has Osteoarthritis | 458 <input type="checkbox"/> Neck pain |
| 442 <input type="checkbox"/> Muscle spasms | 451 <input type="checkbox"/> Has Rheumatism | 459 <input type="checkbox"/> Pain between the shoulders |
| 443 <input type="checkbox"/> Muscle weakness | 452 <input type="checkbox"/> Rheumatoid Arthritis | 460 <input type="checkbox"/> Shoulder/arm pain |
| 444 <input type="checkbox"/> Tremors | 453 <input type="checkbox"/> Joint stiffness in the morning | 461 <input type="checkbox"/> Numbness/tingling in the body |
| 445 <input type="checkbox"/> Frequent headaches | 454 <input type="checkbox"/> Swollen joints | 462 <input type="checkbox"/> Sleep walks |
| 446 <input type="checkbox"/> Often dizzy | 455 <input type="checkbox"/> Leg pain at rest | 463 <input type="checkbox"/> Stutters or stammers |
| 447 <input type="checkbox"/> Frequently feels faint | 456 <input type="checkbox"/> Spinal curvature | 464 <input type="checkbox"/> Nerve pain |
| 448 <input type="checkbox"/> Has Epilepsy | | |

Behavior Patterns

- 150 ☐ Afraid to eat anywhere except home
- 151 ☐ Always needs someone to advise
- 152 ☐ Cries often
- 153 ☐ Difficulty concentrating
- 154 ☐ Difficulty falling asleep
- 155 ☐ Difficulty staying asleep
- 156 ☐ Easily angered
- 157 ☐ Feelings are easily hurt
- 158 ☐ Frequently becomes scared for no reason
- 159 ☐ Frequently miserable or blue
- 160 ☐ Has to be on guard even with friends
- 161 ☐ Often annoyed by people
- 162 ☐ Recurrent bad dreams
- 163 ☐ Sometimes wishes to be dead or away from it all
- 164 ☐ Upset by criticism
- 165 ☐ Poor memory
- 166 ☐ Scared to be alone
- 167 ☐ Strange people or places cause fear
- 168 ☐ Under considerable emotional stress
- 169 ☐ Unhappy when other are happy
- 170 ☐ Brain fog

Urinary

- 555 ☐ Urinates more than 2 times per night
- 556 ☐ Bed wetting
- 557 ☐ Blood in the urine
- 558 ☐ Difficulty starting urination
- 559 ☐ Painful urination
- 560 ☐ Frequent urination
- 561 ☐ Troubled by urgent urination
- 562 ☐ Incontinence when sneezing or laughing
- 563 ☐ Loses bladder control
- 564 ☐ Frequent bladder infections
- 565 ☐ Frequent kidney infections
- 566 ☐ Kidney stones

Men Only

- 585 ☐ Difficulty completing intercourse
- 586 ☐ Difficulty getting or keeping an erection
- 587 ☐ Discharge from the urethra
- 588 ☐ Had a vasectomy
- 589 ☐ Had difficulty fathering children
- 590 ☐ Lumps in the testicles
- 591 ☐ Painful genitals
- 592 ☐ Prostate troubles
- 593 ☐ Sores on external genitalia
- 594 ☐ Herpes
- 595 ☐ Sexual diseases

Women Only

- 610 ☐ Heavy hair growth on face or body
- 611 ☐ Cycles are every 27-29 days
- 612 ☐ Abnormal cycle >29 days and/or <26 days
- 613 ☐ PMS
- 614 ☐ Menstrual cramps
- 615 ☐ Painful periods
- 616 ☐ Acne worse at menstruation
- 617 ☐ Excessive menstrual flow
- 618 ☐ Retains fluid during periods
- 619 ☐ Pre-menstrual depression
- 620 ☐ Currently taking birth control medication
- 621 ☐ Has taken birth control medication more than 1 year
- 622 ☐ Has taken birth control medication within the last year
- 623 ☐ Has had miscarriage
- 624 ☐ Hot flashes
- 625 ☐ Takes hormone replacement medication
- 627 ☐ Diminished sexual desire
- 628 ☐ Painful intercourse
- 629 ☐ Poor or infrequent orgasm
- 630 ☐ Lumps in the breasts
- 631 ☐ Tender breasts
- 633 ☐ Vaginal discharge
- 634 ☐ Bloody spotting discharge
- 635 ☐ Yeast infections
- 636 ☐ Sores on external genitalia
- 637 ☐ Herpes
- 638 ☐ Sexual diseases
- 639 ☐ Endometriosis
- 640 ☐ Breast reduction
- 641 ☐ Breast augmentation
- 642 ☐ Abortion
- 643 ☐ D&C
- 644 ☐ Tubal pregnancy
- 645 ☐ Uterine fibroids
- 646 ☐ Ovarian fibroids
- 647 ☐ Breast fibroids
- 648 ☐ Currently Breastfeeding

Medications

Please list all drugs you are currently taking on a daily basis.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>

Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc.)

<input type="checkbox"/> Dairy	<input type="checkbox"/> Gluten	<input type="checkbox"/> Ragweed	<input type="checkbox"/> Sulfa drugs
<input type="checkbox"/> Eggs	<input type="checkbox"/> Mold	<input type="checkbox"/> Shellfish	<input type="checkbox"/> Tree nuts
<input type="checkbox"/> Garlic	<input type="checkbox"/> Peanut	<input type="checkbox"/> Soy	<input type="checkbox"/> Wheat
<input type="checkbox"/> Other _____			

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

<u>VITAMIN</u>	<u>BRAND</u>	<u>DOSAGE</u>

Dr. Philip Peter Princetta
Chiropractic Functional Medicine

1818 Howard Ave
San Diego, CA 92103
619-231-1778
drp@drprincetta.com