

If you ever been diagnosed with any type of tumor or cancer, please explain: _____

If you ever undergone any surgeries, please explain with approximate dates: _____

Please list any major injuries or accidents you have been treated for with approximate dates, if possible: _____

WOMEN:

I am not menstruating due to: a hysterectomy or menopause

Is your menstrual cycle regular (once every approx. 28-30 days)? Y N If not, please explain: _____

Average length of menstruation _____ days (start to finish)

What do you experience during your menstrual cycle (cramping, bloating, mood swings, etc.): _____

What do you do to relieve the symptoms you described? _____

Are you currently taking a birth control pill? Y N

If you are going through menopause, do you have hot flashes or other symptoms? Y N

How long have you had these symptoms and what are they? _____

If you are currently on any hormone replacement therapy, please list: _____

Are you pregnant or is there a possibility that you are? Y N

Do you suffer from any of these symptoms?

Previously	Currently	Previously	Currently	Previously	Currently
<input type="checkbox"/>	<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Chronic Headaches
<input type="checkbox"/>	<input type="checkbox"/> Ringing in the Ears	<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Heart Disease
<input type="checkbox"/>	<input type="checkbox"/> Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/> Acne	<input type="checkbox"/>	<input type="checkbox"/> Cold Hands / Feet
<input type="checkbox"/>	<input type="checkbox"/> Constipation	<input type="checkbox"/>	<input type="checkbox"/> Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/> Anemia
<input type="checkbox"/>	<input type="checkbox"/> Dry Skin	<input type="checkbox"/>	<input type="checkbox"/> Oily Skin	<input type="checkbox"/>	<input type="checkbox"/> Heartburn
<input type="checkbox"/>	<input type="checkbox"/> Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Yeast Infection
<input type="checkbox"/>	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> Low Cholesterol	<input type="checkbox"/>	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/> Difficult Digestion	<input type="checkbox"/>	<input type="checkbox"/> Scoliosis
<input type="checkbox"/>	<input type="checkbox"/> Inguinal Hernia	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Nervousness
<input type="checkbox"/>	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis A B C	<input type="checkbox"/>	<input type="checkbox"/> Prostate
<input type="checkbox"/>	<input type="checkbox"/> Other _____				

I have never had a problem with any of the above.

If you would like to add anything to the information above, please feel free to use the space below:

