

Date _____

J. Douglas Weinstein, M.Ac., L.Ac.

www.LiveWellMedicine.com
jdouglasweinstein@yahoo.com

_____ **Hershey, Pennsylvania Office:**
1106 Cocoa Avenue
Hershey, PA 17033
717-520-1212

_____ **Columbia, Maryland Office:**
7750 Montpelier Road
Laurel, MD 20723
410-794-6186

New Patient Intake Form

Name _____	Home Phone _____
Address _____	Cell Phone _____
City, State, Zip _____	Work Phone _____
Occupation _____	Email _____
Age _____ Birth Date ____/____/____	Sex _____ Height _____ Weight _____
Family Physician _____	Physician Phone _____
In Case of emergency notify: _____	Contact's Phone _____
Relationship _____	Referred by _____

I. Goals: What would you like to address through treatment?
(For example: stress management, migraines, relaxation, wellness, sleep, pain, energy, etc.)

II. Medications / Supplements / Vitamins Please include *prescription medication, over-the-counter medications,* and any *supplements* that you take on a regular basis. If known, please include: brand, dosage, frequency, and purpose.

III. Lifestyle

1. Hours a week that you work _____

2. How many Servings per day to you use of the following?

Water _____ Coffee _____ Tea _____

Soft Drinks _____ Alcohol _____

3. Cigarettes (packs per day) _____

4. Drug use (recreational) _____

5. Do you have a known history to exposure to *toxic* substances? _____

6. Describe your current exercise regimen:

Frequency per week _____ Activities _____

7. Sleep: how many hours of sleep on an average night _____

Please circle Yes or No

Do you wake feeling well-rested? [Y / N]

Do you have difficulty **falling** asleep? [Y / N]

Do you have difficulty **staying** asleep? [Y / N]

Do you get up at night to urinate? [Y / N] →

If yes, how often? _____

8. Food Intake: Describe your diet in general (i.e. vegetarian, meat, etc.) _____

How many meals a day do you usually eat _____

Do you normally eat breakfast _____

IV. Medical History

Last physical exam / date _____

List surgeries / dates _____

Significant accidents or traumas / dates _____

V. Health: *Check all that apply.*

Please Note: Oriental Medicine treats the individual, not just the symptom. Your answers will greatly support me in assessing your diagnosis. Even if some questions do not seem to be directly related to your condition, they are still relevant to ascertaining the underlying patterns related to your diagnosis. Therefore, please fill out the following pages as thoroughly as you can. If any question is too personal, please feel free to not answer it.

Medical History

<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Coronary artery disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Sudden weight loss	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorder
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Goiter
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Herpes

Cardiovascular

<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands
<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Angina/chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet
<input type="checkbox"/>	<input type="checkbox"/>	Blackouts or fainting	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cold feet
<input type="checkbox"/>	<input type="checkbox"/>	Heart valve problems/murmur	<input type="checkbox"/>	<input type="checkbox"/>	Blood clot	<input type="checkbox"/>	<input type="checkbox"/>	Hot hands or palms
<input type="checkbox"/>	<input type="checkbox"/>	Rapid heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Hot soles of feet
			<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Generally too hot
			<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Generally too cold
			<input type="checkbox"/>	<input type="checkbox"/>	Anemia			
			<input type="checkbox"/>	<input type="checkbox"/>	Edema			

Gastrointestinal

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Hard stools
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool
<input type="checkbox"/>	<input type="checkbox"/>	Mucus in stool
<input type="checkbox"/>	<input type="checkbox"/>	Bowel movement feels incomplete
<input type="checkbox"/>	<input type="checkbox"/>	Frequent laxative use
<input type="checkbox"/>	<input type="checkbox"/>	Loose stools
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea, upon waking in morning
<input type="checkbox"/>	<input type="checkbox"/>	Erratic bowel movements
<input type="checkbox"/>	<input type="checkbox"/>	Alternating diarrhea and constipation
<input type="checkbox"/>	<input type="checkbox"/>	Black stool
<input type="checkbox"/>	<input type="checkbox"/>	Foul smelling stool
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Colitis

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis
<input type="checkbox"/>	<input type="checkbox"/>	Parasites
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal bloating
<input type="checkbox"/>	<input type="checkbox"/>	Gas / flatulence
<input type="checkbox"/>	<input type="checkbox"/>	Hiatal hernia
<input type="checkbox"/>	<input type="checkbox"/>	Lower abdominal cramping / pain
<input type="checkbox"/>	<input type="checkbox"/>	Upper abdominal cramping / pain
<input type="checkbox"/>	<input type="checkbox"/>	Stomach acidity
<input type="checkbox"/>	<input type="checkbox"/>	Reflux
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Gurgling stomach noise
<input type="checkbox"/>	<input type="checkbox"/>	Undigested food in stool
<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Weak digestion
<input type="checkbox"/>	<input type="checkbox"/>	Belching

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Food feels like it sits in stomach
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	<input type="checkbox"/>	Excessive appetite
<input type="checkbox"/>	<input type="checkbox"/>	Bad breath

Musculoskeletal

General:

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Muscle spasms
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling Where? _____
<input type="checkbox"/>	<input type="checkbox"/>	Stiff, all over
<input type="checkbox"/>	<input type="checkbox"/>	elbow
<input type="checkbox"/>	<input type="checkbox"/>	Hand or finger
<input type="checkbox"/>	<input type="checkbox"/>	Upper back
<input type="checkbox"/>	<input type="checkbox"/>	Mid back
<input type="checkbox"/>	<input type="checkbox"/>	Low back

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Leg or calf cramping
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness
Pain / Stiffness in:		
<input type="checkbox"/>	<input type="checkbox"/>	Sacroiliac area
<input type="checkbox"/>	<input type="checkbox"/>	Hip joint
<input type="checkbox"/>	<input type="checkbox"/>	Thigh or upper leg
<input type="checkbox"/>	<input type="checkbox"/>	Calf or lower leg

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Neck
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder blade
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder joint
<input type="checkbox"/>	<input type="checkbox"/>	upper arm
<input type="checkbox"/>	<input type="checkbox"/>	Weak legs
<input type="checkbox"/>	<input type="checkbox"/>	Knee
<input type="checkbox"/>	<input type="checkbox"/>	Weak knees
<input type="checkbox"/>	<input type="checkbox"/>	Ankle
<input type="checkbox"/>	<input type="checkbox"/>	Foot or toe

Is the Pain/Stiffness helped by:

Pressure _____
Heat _____
Cold _____
Other _____

Is the Pain/Stiffness aggravated by:

Pressure _____
Heat _____
Cold _____
Other _____

Eyes

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Nearsighted
<input type="checkbox"/>	<input type="checkbox"/>	Farsighted
<input type="checkbox"/>	<input type="checkbox"/>	Astigmatism
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Night blindness
<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	<input type="checkbox"/>	Floating spots
<input type="checkbox"/>	<input type="checkbox"/>	Pressure behind eyes
<input type="checkbox"/>	<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes
<input type="checkbox"/>	<input type="checkbox"/>	Watery eyes

<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Itchy eyes
<input type="checkbox"/>	<input type="checkbox"/>	Red eyes
<input type="checkbox"/>	<input type="checkbox"/>	Conjunctivitis
<input type="checkbox"/>	<input type="checkbox"/>	Eyeglasses / contacts
<input type="checkbox"/>	<input type="checkbox"/>	Blindness

Skin and Hair

<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>	<input type="checkbox"/>	Moist palms
<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	Ulceration or sores	<input type="checkbox"/>	<input type="checkbox"/>	Fungus on skin
<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Recent moles	<input type="checkbox"/>	<input type="checkbox"/>	Fungus under nails
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Recent change in mole	<input type="checkbox"/>	<input type="checkbox"/>	Weak or brittle nails
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Warts	<input type="checkbox"/>	<input type="checkbox"/>	Loss of hair
<input type="checkbox"/>	<input type="checkbox"/>	Herpes Zoster (shingles)	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	Dandruff
<input type="checkbox"/>	<input type="checkbox"/>	Acne / pimples	<input type="checkbox"/>	<input type="checkbox"/>	Moist feet			

Emotional

<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Tendency to repress emotions	<input type="checkbox"/>	<input type="checkbox"/>	Sadness or grief
<input type="checkbox"/>	<input type="checkbox"/>	Frequent anger or irritation	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	Frequent crying
<input type="checkbox"/>	<input type="checkbox"/>	Frustration	<input type="checkbox"/>	<input type="checkbox"/>	Manic episodes	<input type="checkbox"/>	<input type="checkbox"/>	Indecisiveness
<input type="checkbox"/>	<input type="checkbox"/>	Worry	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive or compulsiveness	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty handling stress
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety or fear	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal feelings			

Respiratory

<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Clear, whitish phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Dry cough	<input type="checkbox"/>	<input type="checkbox"/>	Yellowish phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
<input type="checkbox"/>	<input type="checkbox"/>	Tight, rattling cough	<input type="checkbox"/>	<input type="checkbox"/>	Blood in phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Asthma: difficult to exhale
<input type="checkbox"/>	<input type="checkbox"/>	Loose cough	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma: difficult to inhale
<input type="checkbox"/>	<input type="checkbox"/>	Thick, sticky phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Asthma: worse on exhale
<input type="checkbox"/>	<input type="checkbox"/>	Thin, watery phlegm	<input type="checkbox"/>	<input type="checkbox"/>	Pain with deep breath			
			<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath			

Head, Ears, Nose, Mouth, & Throat

<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Excessive saliva or drooling
<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion, pain	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headache	<input type="checkbox"/>	<input type="checkbox"/>	Sores on tongue
<input type="checkbox"/>	<input type="checkbox"/>	Facial pain	<input type="checkbox"/>	<input type="checkbox"/>	Congestion in ears	<input type="checkbox"/>	<input type="checkbox"/>	Sores in mouth
<input type="checkbox"/>	<input type="checkbox"/>	Jaw tension, or clicking (TMJ)	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	Sores on lips (fever blisters)
<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Frequent dental cavities	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Lump or pit in throat
<input type="checkbox"/>	<input type="checkbox"/>	Gum problems	<input type="checkbox"/>	<input type="checkbox"/>	Nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	Strep throat
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Runny nose	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	Dentures	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Swollen lymph nodes
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, or loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Decreased sense of smell			
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Polyps, nasal			
			<input type="checkbox"/>	<input type="checkbox"/>	Allergies			
			<input type="checkbox"/>	<input type="checkbox"/>	Dry mouth			

Pregnancy and Gynecology (for Women):

<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge: Burning
<input type="checkbox"/>	<input type="checkbox"/>	Heavy flow	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual bloating	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap
<input type="checkbox"/>	<input type="checkbox"/>	Light flow	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual fluid retention	<input type="checkbox"/>	<input type="checkbox"/>	Uterine fibroids
<input type="checkbox"/>	<input type="checkbox"/>	Clots, dark purple	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual headache	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian cysts
<input type="checkbox"/>	<input type="checkbox"/>	Clots, dark brown	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual constipation	<input type="checkbox"/>	<input type="checkbox"/>	Breast cysts or lumps
<input type="checkbox"/>	<input type="checkbox"/>	Clots, red	<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Pelvic inflammatory disease
<input type="checkbox"/>	<input type="checkbox"/>	Light colored blood	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	Difficult deliveries
<input type="checkbox"/>	<input type="checkbox"/>	Painful periods	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge: No odor	<input type="checkbox"/>	<input type="checkbox"/>	C-Sections
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge: Strong odor	<input type="checkbox"/>	<input type="checkbox"/>	Have note begun menstruating
<input type="checkbox"/>	<input type="checkbox"/>	Cramping before period begins	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge: Brownish	<input type="checkbox"/>	<input type="checkbox"/>	IUD
<input type="checkbox"/>	<input type="checkbox"/>	Cramping after period begins	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge: White/Curd-like	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Low backache with period	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge: Frothy & profuse	<input type="checkbox"/>	<input type="checkbox"/>	Other Birth control
<input type="checkbox"/>	<input type="checkbox"/>	Spotting between periods	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge: Itchy	<input type="checkbox"/>	<input type="checkbox"/>	Cannot maintain pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Missed periods				<input type="checkbox"/>	<input type="checkbox"/>	Infertility
<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual irritability				<input type="checkbox"/>	<input type="checkbox"/>	Pregnant
<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual emotional sensitivities				<input type="checkbox"/>	<input type="checkbox"/>	Nursing
						<input type="checkbox"/>	<input type="checkbox"/>	Morning Sickness / nausea

Number of Pregnancies _____

Miscarriages _____

Abortions _____

Hysterectomy, reason for: _____

Age at first menses: _____

Starting date of last menses (when started bleeding = Day 1): _____

Number of Births _____

Premature Births _____

Age of Children _____

Oophorectomy, reason for: _____

Age when menses stopped: _____

Urinary and Genital

<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>	<i>Past</i>	<i>Current</i>	<i>Condition</i>
<input type="checkbox"/>	<input type="checkbox"/>	Scanty, or small amount of urine	<input type="checkbox"/>	<input type="checkbox"/>	Decreased flow of urine	<input type="checkbox"/>	<input type="checkbox"/>	Sores on genitals
<input type="checkbox"/>	<input type="checkbox"/>	Dark urine	<input type="checkbox"/>	<input type="checkbox"/>	Flow does not stop quickly	<input type="checkbox"/>	<input type="checkbox"/>	Pain during intercourse
<input type="checkbox"/>	<input type="checkbox"/>	Strong smelling urine	<input type="checkbox"/>	<input type="checkbox"/>	Dribbling	<input type="checkbox"/>	<input type="checkbox"/>	Low sexual energy
<input type="checkbox"/>	<input type="checkbox"/>	Cloudy urine	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>	Excessive sexual energy
<input type="checkbox"/>	<input type="checkbox"/>	Unable to hold urine	<input type="checkbox"/>	<input type="checkbox"/>	Pain or burning during urination	<input type="checkbox"/>	<input type="checkbox"/>	Inability to achieve orgasm
<input type="checkbox"/>	<input type="checkbox"/>	Urgency to urinate	<input type="checkbox"/>	<input type="checkbox"/>	Pain in bladder area	<input type="checkbox"/>	<input type="checkbox"/>	Low sperm count
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Inability to maintain erection
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Urinating	<input type="checkbox"/>	<input type="checkbox"/>	Bladder infection	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems
			<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection			
			<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones			