Date:____/____/______ **Reason for visit:____________________** **Allergies:__________**

Name:__________________________ **DOB____/____/______** **Age:_______**

Health Review

Please indicate if you are having problems in the following area(s):

General wellness	*Y*	*N*	Muscles/joints/bones	*Y*	*N*
Eyes	*Y*	*N*	Skin	*Y*	*N*
Ears/nose/throat	*Y*	*N*	Neurological	*Y*	*N*
Heart/circulation	*Y*	*N*	Psychiatric	*Y*	*N*
Lungs/breathing	*Y*	*N*	Endocrine	*Y*	*N*
Stomach/digestion	*Y*	*N*	Blood/lymph	*Y*	*N*
Reproduction/urinary	*Y*	*N*	Allergies	*Y*	*N*

Other:____

If yes, please explain:____

Are you experiencing any vaginal or urinary:

☐ *Discharge* ☐ *Odor* ☐ *Burning* ☐ *Itching* ☐ *Frequency* ☐ *Urgency* ☐ *Loss of urine*

Are you having any libido changes or pain with intercourse? *Y* *N*

If yes, please explain:____

Has there been any change in your medical history since your last visit? *Y* *N*

If yes, please explain:____

Has there been any change in your social history since your last visit? *Y* *N*

If yes, please explain:____

Are you taking any new medications since your last visit? *Y* *N*

If yes, please list:____

Do you smoke?	*Y*	*N*	About_____cigarettes per day
Do you drink alcohol?	*Y*	*N*	About_____drinks per week
Do you diet?	*Y*	*N*	What type?_______________
Do you exercise?	*Y*	*N*	How often and what type?_______________
Do you take calcium?	*Y*	*N*	If so, how much?_______________