



Please check all conditions you currently have or have had

<u>General Questions</u>	<u>Cardiovascular</u>	<u>Kidneys &amp; Urinary Tract</u>	<u>Musculoskeletal</u>
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Angina	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Leg cramps	<input type="checkbox"/> Brown urine dribbling after urination	<input type="checkbox"/> Back pain <input type="checkbox"/> Joint aches
<input type="checkbox"/> Change in sleep patterns	<input type="checkbox"/> Ankle swelling	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Bursitis <input type="checkbox"/> Tendinitis
<input type="checkbox"/> Change in activity capacity	<input type="checkbox"/> Awakening at night short of breath & getting out of bed	<input type="checkbox"/> Excessive thirst -involuntary	<input type="checkbox"/> Gout
<b><u>Neurological and Psychiatric</u></b>	<input type="checkbox"/> Cardiac catheterization	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Urinating frequently (day)	<input type="checkbox"/> Abnormal Blood Counts
<input type="checkbox"/> Headaches	<input type="checkbox"/> Congenital heart defects	<input type="checkbox"/> Urinating frequently (night)	<input type="checkbox"/> Blood clots in legs/lungs
<input type="checkbox"/> Depression	<input type="checkbox"/> Dizziness when standing up quickly	<input type="checkbox"/> Urine hesitancy	<input type="checkbox"/> Bone Marrow Biopsy
<input type="checkbox"/> Meningitis	<input type="checkbox"/> Heart attacks	<input type="checkbox"/> Weak flow	<input type="checkbox"/> Easy bleedings
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Heart failure	<input type="checkbox"/> Frequent bladder infections	<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Seizure	<input type="checkbox"/> High or low blood pressure	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Joint swelling
<input type="checkbox"/> Stroke	<input type="checkbox"/> Irregular heart rate	<input type="checkbox"/> Kidney stone	<input type="checkbox"/> Morning stiffness
<input type="checkbox"/> Tingling	<input type="checkbox"/> Purple fingers or lips	<b><u>Endocrine</u></b>	<input type="checkbox"/> Muscle aches
<input type="checkbox"/> Tremors	<input type="checkbox"/> Leg pain that resolves with rest	<input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle Cell	<b><u>Gastrointestinal</u></b>
<input type="checkbox"/> Memory loss	<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Abnormal body hair	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Gallstones
<input type="checkbox"/> Fainting spells, dizziness	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Changes in skin texture	<input type="checkbox"/> Reflux <input type="checkbox"/> Vomiting
<input type="checkbox"/> Head injuries	<b><u>Respiratory</u></b>	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Ulcers <input type="checkbox"/> Heartburn
<input type="checkbox"/> Blackouts or near blackouts	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Indigestion
<input type="checkbox"/> Change in sensation anywhere on your body	<input type="checkbox"/> Asthma	<input type="checkbox"/> History of "bordering" diabetes	<input type="checkbox"/> Abdominal pain
<input type="checkbox"/> Localized weakness or numbness	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Increased loss of hair	<input type="checkbox"/> Anal fissures
<b><u>Ears, Eyes, Nose &amp; Throat</u></b>	<input type="checkbox"/> Breathlessness when lying flat	<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Black tarry stools
<input type="checkbox"/> Hay fever	<input type="checkbox"/> Prolonged cough	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Vomiting blood
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Coughing up blood	<b><u>Male &amp; Female</u></b>	<input type="checkbox"/> Constipation
<input type="checkbox"/> Polyps	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Painful sexual intercourse	<input type="checkbox"/> Nausea
<input type="checkbox"/> Allergy	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Loss of sexual interest	<input type="checkbox"/> Problems swallowing
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Unprotected sex	<input type="checkbox"/> Hiatal hernia
<input type="checkbox"/> Goiter	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Groin itching	<input type="checkbox"/> Intestinal obstruction
<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Frequent infections - (bronchitis)	<input type="checkbox"/> Sexually transmitted diseases	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Double vision	<b><u>Skin</u></b>	<b><u>Males Only</u></b>	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Gum problems	<input type="checkbox"/> Abscess <input type="checkbox"/> Dandruff	<input type="checkbox"/> Hernia <input type="checkbox"/> Sterility	<input type="checkbox"/> Red blood after bowel movements
<input type="checkbox"/> Eye problems	<input type="checkbox"/> Acne <input type="checkbox"/> Oily skin	<input type="checkbox"/> Bloody ejaculation	<b><u>Females Only</u></b>
<input type="checkbox"/> Ear infections	<input type="checkbox"/> Boils <input type="checkbox"/> Rashes	<input type="checkbox"/> Inability to complete intercourse	<input type="checkbox"/> D + C <input type="checkbox"/> Hot flashes
<input type="checkbox"/> Glasses/contacts	<input type="checkbox"/> Hives <input type="checkbox"/> Dry skin	<input type="checkbox"/> Lump on testicle	<input type="checkbox"/> Hernia <input type="checkbox"/> Fibroids
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis	<input type="checkbox"/> Penile discharge	<input type="checkbox"/> Abn bleedings between cycles
<input type="checkbox"/> Ear discharge/pain	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Premature ejaculation	<input type="checkbox"/> Abnormal pap smear
<input type="checkbox"/> Frequent nosebleeds	<input type="checkbox"/> Athlete's foot	<input type="checkbox"/> Problems maintaining or keeping erection	<input type="checkbox"/> Bleeding after intercourse
<input type="checkbox"/> Ringing in your ears	<input type="checkbox"/> Excessive body odor	<input type="checkbox"/> Prostate disease	<input type="checkbox"/> Complications w/ pregnancy
<input type="checkbox"/> Sinus Infections	<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Sores on penis or warts	<input type="checkbox"/> PMS
<input type="checkbox"/> Swollen glands	<input type="checkbox"/> Fungal infection	<input type="checkbox"/> Testicular pain	<input type="checkbox"/> Endometriosis
	<input type="checkbox"/> Nail problems	<input type="checkbox"/> Testicular swelling	<input type="checkbox"/> Heavy bleeding during cycles
	<input type="checkbox"/> Moles – Irregular		<input type="checkbox"/> Discharge from breasts
	<input type="checkbox"/> Moles – change/new		<input type="checkbox"/> Ovarian cysts