

WHOLE HEALTH SOLUTIONS INITIAL AND YEARLY PATIENT HISTORY

Endocrine	
Swollen eyes	<input type="checkbox"/>
Difficulty losing weight	<input type="checkbox"/>
Trouble getting going in morning	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>
Dry Skin	<input type="checkbox"/>
Difficulty tolerating cold (more than other people)	<input type="checkbox"/>
Difficulty tolerating heat (more than other people)	<input type="checkbox"/>
Irritability	<input type="checkbox"/>
Hot flashes	<input type="checkbox"/>
Loss of attention to detail	<input type="checkbox"/>
Poor recovery from activity	<input type="checkbox"/>
Genitourinary	No complaints <input type="checkbox"/>
Pain when urinating	<input type="checkbox"/>
Frequent urination	<input type="checkbox"/>
Urgency of urination	<input type="checkbox"/>
Slowing of the urinary system	<input type="checkbox"/>
Sense of incomplete evacuation	<input type="checkbox"/>
Unable to hold urine when coughing, laughing, lifting or exercising	<input type="checkbox"/>
Blood in the urine	<input type="checkbox"/>
Sugar in the urine	<input type="checkbox"/>
Protein in the urine	<input type="checkbox"/>
Kidney infection	<input type="checkbox"/>
Bladder infection	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>

Musculo-skeletal	No complaints <input type="checkbox"/>
Arthritis	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>
Tendonitis	<input type="checkbox"/>
Tennis elbow	<input type="checkbox"/>
Disc disease	<input type="checkbox"/>
Sciatica	<input type="checkbox"/>
Red or swollen joints	<input type="checkbox"/>
Gout	<input type="checkbox"/>
Back or neck pain	<input type="checkbox"/>
Arm or leg pain	<input type="checkbox"/>
Injury or fractures	<input type="checkbox"/>
	<input type="checkbox"/>
Neurological	No complaints <input type="checkbox"/>
Frequent headaches	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>
Loss of vision	<input type="checkbox"/>
Loss of speech	<input type="checkbox"/>
Weakness in arms or legs	<input type="checkbox"/>
Numbness in extremities	<input type="checkbox"/>
"Pins and needles" or other unusual symptoms	<input type="checkbox"/>
frequent dizzy spells	<input type="checkbox"/>
Faintness/lightheadedness	<input type="checkbox"/>
Feeling like the room is spinning	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>
Stroke	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>
Nervous breakdown	<input type="checkbox"/>
Blackouts	<input type="checkbox"/>

Questions for women	No complaints <input type="checkbox"/>
Pregnancy	<input type="checkbox"/>
Vaginal discharge	<input type="checkbox"/>
Irregular menstruation	<input type="checkbox"/>
Pre-menstrual syndrome	<input type="checkbox"/>
Post menopausal	<input type="checkbox"/>
Female disorder treatment	<input type="checkbox"/>
Vaginal itching	<input type="checkbox"/>
Unusual or irregular vaginal bleeding	<input type="checkbox"/>
Painful intercourse	<input type="checkbox"/>
Difficulty with sexual function	<input type="checkbox"/>
Breast complaints	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>
Are you concerned about exposure to sexually transmitted diseases?	Yes <input type="checkbox"/> No <input type="checkbox"/>
When was your last period?	
Painful menstruation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you use any birth control?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Continue in next column	

Do you use any type of hormone replacement therapy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Decreased libido?	<input type="checkbox"/>
Questions for men	No complaints <input type="checkbox"/>
Pain in the testicles	<input type="checkbox"/>
Prostrate infection	<input type="checkbox"/>
Sores in the genital area	<input type="checkbox"/>
Injury to the groin area	<input type="checkbox"/>
Penile discharge	<input type="checkbox"/>
Impotence problems	<input type="checkbox"/>
Are you concerned about exposure to sexually transmitted diseases?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Decreased libido	<input type="checkbox"/>
Too emotional	<input type="checkbox"/>
Decreased muscle strength	<input type="checkbox"/>
Cellulite or excess breast tissue	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>

WHS PATIENT INTAKE HISTORY
29 December 2010

Write any additional history you would like us to know here: