

Continued

Head, Eyes, Ears, Nose, and Throat

- | | | |
|--|--|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Wear Glasses | <input type="checkbox"/> Eye Strain | <input type="checkbox"/> Eye Pain |
| <input type="checkbox"/> Poor Vision | <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Color Blindness |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Spots in Front of Eyes |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> Recurrent Sore Throats |
| <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Sores on Lips or Tongue |
| <input type="checkbox"/> Teeth Problems | <input type="checkbox"/> Jaw Clicks | |

Headaches (Where and When)? _____

Any other head or neck problems? _____

Respiratory

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Cough | | | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Asthma | |
| <input type="checkbox"/> Difficulty in breathing when laying down | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Pain with Deep Breath | |
| <input type="checkbox"/> Production of Phlegm (What color? _____) | | | |

Gastrointestinal

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Black Stools | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Rectal Pain | <input type="checkbox"/> Hemorrhoids |
| <input type="checkbox"/> Abdominal Pain or Cramps | <input type="checkbox"/> Chronic Laxative use | |

Any other problems with your stomach or intestines? _____

Genito-Urinary

- | | | |
|--|---|--|
| <input type="checkbox"/> Pain When Urinating | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Urgency to Urinate | <input type="checkbox"/> Poor Bladder Control | <input type="checkbox"/> Dark Urine |
| <input type="checkbox"/> Decrease in Flow | <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Burning Urination |

Men Only

- | | |
|--|--|
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Pain in testicles |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Low sex drive |

Do you wake up to urinate? _____ How Often? _____

Any particular color of urine? _____

Any other problems with your genital or urinary system? _____