Personalized Lifestyle Medicine Center
Adult Medical Questionnaire

To all our patients:
WELCOME. We will be using this form to assess your wellbeing and functional status - Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Please do not feel you are obligated to answer any question that makes you feel uncomfortable. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us in formulating a treatment plan. If you have questions or concerns, we will help you with those after this form is completed. Thank you.

To our established patients:
WELCOME BACK. We will be asking you to complete this form at the time of your annual physical or after any long gaps in care. While we recognize that you may have shared this information with us in the past, completing this form will allow for a more efficient use of your time with your clinician. Thank you.

First Name: _____ Middle Name: _____ Last Name: _____

Nickname: _____

Birth Date: ___/___/_____ Age: _____

month day year

Birth Sex: _____ Gender Identity: _____

Address:_____ City: _____ State: _____ ZIP: _____

Home Phone: (____) ____-_____ Email Address: _____

How did you find us? _____

If Internet, Which website? _____

Date form completed: _____

History of your Present Illness:

1. Please check appropriate box(es):

☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic
☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other

Place of Birth: _____

2. Current Complaints:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Postnasal Drip	Moderate	Antihistamines	Moderate
a.			
b.			
c.			
d.			
e.			
f.			

Your Past History:

3. Past Medical and Surgical History:

	ILLNESSES	WHEN	COMMENTS
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Autoimmune Disease		
e.	Bronchitis/COPD/Emphysema		
f.	Cancer		
g.	Chronic Fatigue Syndrome		
h.	Congestive Heart Failure		
i.	COVID Infection		
j.	Coronary Artery Disease (Angina)		
k.	Crohn's Disease or Ulcerative Colitis		
l.	Diabetes Mellitus		
m.	Epilepsy, convulsions, or seizures		
n.	Eye Disorders		
o.	Fibromyalgia		
p.	Gallstones		
q.	Gout		
r.	Hepatitis		
s.	High Cholesterol, High Triglycerides		

	ILLNESSES	WHEN	COMMENTS
t.	High Blood Pressure (Hypertension)		
u.	Irritable Bowel Syndrome		
v.	Kidney stones		
w.	Mononucleosis		
x.	Pneumonia		
y	Sinusitis/Allergic Rhinitis		
z	Sleep apnea		
aa.	Stroke		
ab.	Thyroid disease		
ac.	Other (describe)		
	INJURIES	**WHEN**	**COMMENTS**
ad.	Back injury		
ae.	Broken bones (describe)		
af.	Head injury		
ag.	Neck injury		
ah.	Other (describe)		
	SCREENING EXAMINATIONS	**WHEN**	**COMMENTS**
ai.	Eye Examination		
aj.	Mammogram		
ak.	Gynecological Exam		
al.	Colonoscopy/Cologuard		
am.	Rectal Examination		
an.	Prostate Specific Antigen (PSA)		
ao.	Bone Density (DEXA or Ultrasound)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ap.	Abdominal Xray/Ultrasound/CT Scan/MRI		
aq.	Back (Lumbar) Xray/CT Scan/MRI		
ar.	Bone Scan		
as.	Brain CT Scan/MRI		
at.	Carotid Ultrasound/Duplex Scan		
au.	Chest Xray/CT Scan/MRI		
av.	EKG (Electrocardiogram)		
aw.	Exercise Stress Test		
ax.	Foot Exam (Podiatry)		
ay.	Heart Scan (Calcium Score)		
az.	Last Complete Physical Exam		
ba.	Neck (Cervical) Xray/CT Scan/MRI		
bb.	Other (describe)		
bc.	Skin (Dermatology) Exam		

	OPERATIONS	WHEN	COMMENTS
bd.	Appendectomy		
be.	Cataract Surgery		
bf.	Dental Surgery		
bg.	Gall Bladder Surgery		
bh.	Hernia Repair		
bi.	Hysterectomy		
bj.	Orthopedic Surgery		
bk.	Tonsillectomy		
bl.	Other (describe)		

4. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

5. Please list Practitioners involved in your care:

Name:	Specialty:	City, Town:	Phone:

6. What medications are you taking now? Include non-prescription drugs.

	Medication Name	Dosage and Frequency	When did you start?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

7. How often have you have taken antibiotics?

	< 5 times	≥ 5 times
Infancy/ Childhood		
Teen		
Adulthood		

8. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	≥ 5 times
Infancy/ Childhood		
Teen		
Adulthood		

9. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Dosage	Date Started
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

10. Are you allergic to any medications or supplements or foods? Yes____ No_____

Medications/Supplements/Foods	Reaction	Date
1.		
2.		
3.		
4.		
5.		
6.		

11. Please list all recent vaccinations.

Vaccinations	Date	Reactions?
1.		
2.		
3.		
4.		
5.		
6.		

Details of Your Life:

12. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
    Example: Wendy, age 47, Wife
    _____
    _____
    _____

13. What is your occupation? _____
    _____

14. Please tell us about your education. _____
    _____

15. How much days have you missed at work or school in the past year?
    a. _____ 0 days
    b. _____ 1-3 days
    c. _____ 4-10 days
    d. _____ more than 10 days

16. Previous jobs:
    _____
    _____

17. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes____ No____
    If yes, which one(s)? _____ lead _____cadmium
    _____ arsenic _____mercury
    _____ aluminum

18. Have you, to your knowledge, been exposed to mold in your job or at home? Yes____ No____
    If yes, details please: _____
    _____

19. Have you lived or traveled outside of the United States? Yes____ No____
    If so, when and where? _____
    _____

20. Have you ever lived or worked in an environment that has been hard to tolerate? Yes____ No____
    If so, when and where? _____
    _____

21. Do you have any pets or farm animals? Yes____ No____
    If yes, where do they live?
    a. _____ indoors
    b. _____ outdoors
    c. _____ both indoors and outdoors

22. Do you feel worse at certain times of the year? Yes____ No____
    If yes, when? _____spring _____fall
    _____summer _____winter

23. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With your attitude					
e. With your parents					
f. With your spouse or partner					
g. With your children					
h. With close friends					

24. Are you currently, or have you ever been, married? Y____ N____ If so, when? _____
Are you currently, or have you ever been, separated? Y____ N____ If so, when? _____
Are you currently, or have you ever been, divorced? Y____ N____ If so, when? _____
Are you currently, or have you ever been, remarried? Y____ N____ If so, when? _____
Are you currently, or have you ever been, widowed? Y____ N____ If so, when? _____
Comments: _____
_____

25. What is your spouse's or partner's occupation? _____

26. What are your hobbies and leisure activities?_____
_____

27. What is the attitude of those close to you about your illness?
_____Supportive
_____Non-supportive

28. Have you or your family recently experienced any major life changes? Yes____ No____
If yes, please comment: _____
_____

29. Have you experienced any major losses in life? Yes____ No____
If so, please comment: _____
_____

30. How important is religion and spirituality for you and your family's life?
a. _____ not at all important
b. _____ somewhat important
c. _____ extremely important

31. Do you have a regular religious, spiritual or relaxation practice? Yes____ No____
Please Describe: _____
How often and for what duration do you practice? _____

32. Does your religious faith or spiritual practice influence how you take care of yourself and your health?
Yes____ No____

33. Unfortunately, abuse and violence of all kinds (verbal, emotional, physical, and sexual) can be significant contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes. Please do your best to answer the following questions:

    a. Would you feel safer discussing any of these issues privately? Yes____ No____
    If so, please check yes, and leave the following questions unanswered.

    b. Did you feel safe growing up? Yes____ No____

    c. Have you been involved in abusive relationships in your life? Yes____ No____

    d. Was alcoholism or substance abuse present in your childhood home? Yes____ No____

    e. Has alcoholism or substance abuse been problematic in your adult relationships? Yes____ No____

    f. Do you currently feel safe in your home? Yes____ No____

    g. Do you feel safe, respected and valued in your current relationship? Yes____ No____

    h. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse? Yes____ No____

34. Have you ever had psychotherapy or counseling? Yes____ No____
    Currently? Yes____ No_____ Previously? Yes____ No_____ If so, from _____ to _____
    What kind? _____
    Comments: _____

36. Do you have a Living Will? Yes____ No____
    Do you have a Medical Power of Attorney? Yes____ No____

Social Habits:

37. Have you ever drunk alcohol? Yes_____ No_____
    Do you currently drink alcohol? Yes_____ No_____
    Year quit if applicable: _____

    If yes to currently consumption, what is your approximate intake of these beverages?
    Beer:
    ☐ None ☐ Occasional ☐ Often If consumed, how many per week? _____
    Wine:
    ☐ None ☐ Occasional ☐ Often If consumed, how many per week? _____
    Hard Liquor:
    ☐ None ☐ Occasional ☐ Often If consumed, how many per week? _____

    Have you ever had a problem with alcohol? Yes_____ No_____
    If yes, please indicate time period (month/year). From: _____ To: _____

    Do you have or do others express concerns about your drinking? _____
    _____

38. Have you ever used recreational drugs? Yes_____ No_____

39. Have you ever used tobacco or nicotine products? Yes_____ No_____
Do you currently? Yes_____ No_____
Year quit if applicable: _____

If yes, what type of products have you used? _____Cigarette _____ Smokeless _____ Electronic
_____Cigar _____Pipe _____Patch/Gum

If yes, number of years as a nicotine user _____ Amount per day _____

Do you have or do others express concerns about your smoking? _____
_____

Are you exposed to second hand smoke regularly? Yes_____ No_____

40. Have you ever drunk caffeinated beverages? Yes_____ No_____
Do you currently? Yes_____ No_____
Year quit if applicable: _____

If yes, what is your approximate intake of these beverages?
Coffee:
☐ None ☐ Occasional ☐ Often If consumed, how many per week? _____
Tea:
☐ None ☐ Occasional ☐ Often If consumed, how many per week? _____
Caffeinated Soft Drinks:
☐ None ☐ Occasional ☐ Often If consumed, how many per week? _____

Have you ever had a problem with caffeine? Yes_____ No_____
Please describe: _____

Exercise Habits:

41. Do you exercise regularly? Yes____ No____

If so, how many times a week?
1._____1x
2._____2x
3._____3x
4._____4x
5._____5x or more

When you exercise, how long is each session?
1._____ ≤15 minutes
2._____ 16-30 minutes
3._____ 31-45 minutes
4._____ 46-60 minutes
5. _____ > 60 minutes

What type of exercise is it?
_____ Running/Jogging _____ Weight lifting (Resistance training)
_____ Walking _____ Water Aerobics/Sports
_____ Aerobics/Spin Classes/Zumba _____ Yoga/Pilates/Tai Chi
_____ Other (please describe): _____

Do you enjoy exercise? Yes____ No____

Dietary Habits:

42. Are you on a special diet? Yes_____ No_____
    Please select all applicable descriptions:

_____ Mediterranean	_____ Vegetarian	_____ Organic or Whole Foods
_____ Low Glycemic or Diabetic	_____ Vegan	_____ Dairy Free
_____ Gluten Free	_____ Paleo	_____ other: _____

Comments: _____

43. Number of meals you usually eat per day? _____

44. How many glasses of water do you drink per day? _____

If you received a food plan diary with your welcome packet, please complete and return. You may in that case, skip question 45. Thank you.

45. Place a check mark next to the food/drink that applies to your current diet.

	Usual Breakfast	√		**Usual Lunch**	√		**Usual Dinner**	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

46. How much of the following do you consume each week?

a. Candy	
b. Chocolate	
c. Desserts	
d. Salty snacks	
e. Fried food	
f. Fast food	
g. Soft drinks	
h. Diet soft drinks	

47. Is there anything special about your diet that we should know? Yes____ No____
If yes, please explain: _____
_____

48. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?

Yes____ No____
If yes, are these symptoms associated with any particular foods or supplement(s)? Please name the food(s) or supplement(s) and associated symptom(s). Example: Milk – gas and diarrhea.
_____ _____
_____

49. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____
If yes, are these symptoms associated with any particular foods or supplement(s)? Please name the food(s) or supplement(s) and associated symptom(s). Example: Milk – sinus congestion.
_____
_____

50. Do you feel much **worse** when you eat a lot of these foods:
____high fat foods
____high protein foods
____high carbohydrate foods (breads, pastas, potatoes)
_____refined sugar (junk food)
_____fried foods
_____alcoholic drinks
_____other _____

51. Do you feel much **better** when you eat a lot of these foods:
____high fat foods
____high protein foods
____high carbohydrate foods (breads, pastas, potatoes)
_____refined sugar (junk food)
_____fried foods
_____alcoholic drinks
_____other _____

52. Does skipping a meal greatly affect your symptoms? Yes____ No____

53. Have you ever had a food that you craved or really "binged" on over a period of time?
Yes____ No____
If yes, what food(s)? _____ _____
_____

54. Do you have an aversion to certain foods? Yes____ No____
If yes, what foods? _____

55. What do you consider a good weight for yourself? ____ How tall are you? _____

My current weight is: ____ One year ago my weight was: _____ At age 21, my weight was: _____

What is the most you have ever weighed? _____ How old were you? _____

Sleep Habits:

56. How many hours do you sleep each night? _____

Is your sleep interrupted? Yes____ No____ If so, how often? _____

Do you wake rested _____ or tired _____?

When are you most energetic? Morning ___ Afternoon ____ Evening _____

Do you have a midafternoon slump? Yes____ No____ If so, how often? _____

Do you feel like napping during the day? Yes____ No____ If so, how often? _____

If you nap, do you wake rested _____ or tired _____ or no difference _____?

Do you dream during sleep? Yes____ No____ If so, how often? _____

Do you recall your dreams? Yes ____ No ____

Family History:

57. For each member of your family, follow the line across the page and check the boxes for their present state of health, and any illnesses they have had. Circle appropriates choice for sister/brother and for daughter/son.

*(Note: Except for **spouse**, Family refers to **blood** or **natural** relatives.)* **PRINT NAMES BELOW**	**Good Health**	**Poor Health**	**Current Age**	**Deceased**	**Write in age and cause of death. Include accidents and suicides.**	**Alcoholism**	**Allergies or Asthma**	**Anemia**	**Autoimmune Diseases**	**Dementia**	**Diabetes**	**Cancer**	**Heart Disease**	**Hypertension**	**Psychiatric Disease**
Father															
Mother:															
Sister/Brother:															
Sister/Brother:															
Sister/Brother:															
Sister/Brother:															
Sister/Brother:															
Spouse:															
Daughter/Son:															
Daughter/Son:															
Daughter/Son:															
Daughter/Son:															
Paternal relatives (in each box, write in how many affected with condition):															
Maternal relatives (in each box, write in how many affected with condition):															

58. Any other family history we should know about? Yes____ No____
If so, please comment: _____
_____
_____

Review of Systems

Please answer these questions as they apply to your birth sex and gender identity.

Female:

59. Have you ever been pregnant? (If no, skip to question 60.) Yes____ No____

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

Did you develop toxemia (high blood pressure)? Yes____ No____

Have you had other problems with pregnancy? Yes____ No____

If so, please comment: _____

_____

60. Do you do breast self-examinations? Yes____ No____

61. Are you sexually active? Yes____ No___

62. Age at first period: _____ 63. When was your last menstrual period? _____

64. Have you ever used birth control pills? Yes____ No____
Are you taking them now? Yes____ No____

65. If yes to 64, did taking the pill agree with you? Yes____ No____

66. Do you currently use contraception? Yes____ No____
If yes, what type of contraception do you use? _____

67. Are you in menopause? Yes____ No____
If yes, age at last period_____

68. Are you on hormone replacement therapy? Yes____ No____

69. How long have you been on hormone replacement therapy (if applicable)? _____

Male:

70. Are you sexually active? Yes_____ No_____

71. Have you ever experienced erectile dysfunction Yes_____ No_____

72. Do you currently use contraception? Yes_____ No_____
If yes, what type of contraception do you use? _____

73. Have you ever been on hormone replacement therapy? Yes_____ No_____

74. How long have you been on hormone replacement therapy (if applicable)? _____

75. Please check if these symptoms occur presently **or** have occurred in the past 6 months.

GENERAL:	**Mild**	**Mod-erate**	**Severe**
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	**Mild**	**Mod-erate**	**Severe**
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches: Around eyes			
Arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES:			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			

MOOD/NERVES, Continued:	Mild	Mod-erate	Severe
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
EATING:			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			
DIGESTION:			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of: Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			

DIGESTION, Continued:	Mild	Mod-erate	Severe
Fissures			
Flatus (passing gas)			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
SKIN PROBLEMS:			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Dryness			
Where?			
Ears get red			
Easy bruising			
Eczema			

SKIN PROBLEMS, continued:	Mild	Mod-erate	Severe
Herpes - oral			
Herpes - genital			
Hives			
Itching			
Jock itch			
Lackluster skin			
Moles w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
NAILS:			
Bitten			
Brittle			
Curve up			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Finger nails			
Toenails			
White spots/lines			

LYMPH NODES:			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			

RESPIRATORY:	Mild	Mod-erate	Severe
Bad breath			
Bad odor in nose			
Cough - dry			
Cough - productive			
Hay fever : Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

URINARY:	Mild	Mod-erate	Severe
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Urgency			
FEMALE REPRODUCTIVE:			
Breast cysts			
Breast lumps			
Breast tenderness			
Cyst, Ovarian			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Infection			
Impotence			
Mass in Testicles			
Poor libido (sex drive)			
Prostate issues			

The information I have provided is true and accurate to the best of my knowledge.

_____ _____ _____

Signature: Name: Date:

Revised 28 May 2022