REGENESIS WELLNESS CENTER OF SCOTTSDALE

Dr. Alexander de Soler N.M.D.

HEALTH HISTORY QUESTIONNAIRE

(All questions contained in this questionnaire are strictly confidential and will become part of your medical record. All questions within this form have relevance to your overall health and will impact your course of treatment, so it is imperative you be as honest as possible to ensure the greatest therapeutic outcome.)

Name (Last, First, M.I.):		☐ M ☐ F	**Date of Birth:**	
HAPPY WITH YOUR WORK? YES ☐ NO ☐	**Occupation:**		**Hours worked per week:**	
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Previous or referring doctor:			**Date of last physical exam:**	

HOME ADDRESS:

HOME PHONE: ________________ **CELL PHONE:** ______ ____________ **EMAIL ADDRESS:** ______________________@__________

My signature gives the center permission to send me monthly self care health articles via the internet:

Signature ____ Date:________________

EMERGENCY CONTACT NAME: ___________________________ **CONTACT NUMBER:** ____________________

Childhood illness:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Whooping Cough
	☐ Frequent infections (location:__________________) ☐ Other (please describe: ___________________________)

Immunizations and Vaccination dates:	☐ Chickenpox	☐ Diphtheria	☐ Hepatitis	☐ Influenza	☐ MMR Measles, Mumps, Rubella
	☐ Pertussis	☐ Polio	☐ Tetanus	☐ Other	

List any medical problems that other doctors have diagnosed:

Have you ever tried other treatments which were successful / unsuccessful for the current complaint(s)?

What is your greatest health concern?

How does it limit you the most?

Accidents / Traumas

Year	Injuries sustained	

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

CONFIDENTIAL HEALTH HISTORY INTAKE

	Do you wake rested? Do you snore? Do you sleep walk?		
Blood type	What is your blood type?		
Hobbies	What do you like to do for fun?		
Energy Level	On a scale of 0-10 (with 10 being really great energy and 0 being no energy) how would you rate yourself on average?		
Exercise	□ Sedentary (No exercise)		
	□ Mild exercise (i.e., dimb stairs, walk 3 blocks, golf)		
	□ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	□ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?	□ Yes	□ No
	If yes, are you on a physician prescribed medical diet?	□ Yes	□ No
	On average what do you eat in a single day? Breakfast: Lunch: Dinner: Snacks: Water intake:		
	Are there any foods you enjoy? Are there any foods you dislike?		
	# of meals you eat in an average day?		
	Have you experienced unexplainable weight loss/gain within the past 6 months?		
Sugar / Candy	Eat sugery candies / foods on a regular basis?	□ Yes	□ No
	Please indicate preferences and frequency:		
Fast foods / Restaurants	How many times per week do you eat at a fast-food restaurant?		
	How many times per week do you eat at a regular restaurant?		

Liquid intake	□ Water (glasses per day:__________)	□ Coffee (cups per day: __________)	□ Tea (cups per day: _________)	□ Cola (cans per day: __________)
	□ Energy Drinks (cans per day:__________)	□ Other (amount per day:__________)		

Alcohol	Do you drink alcohol?	□ Yes	□ No
	If yes, what kind?		
	How many drinks per week?		
Tobacco	Do you use tobacco?	□ Yes	□ No
	Please indicate type used and frequency:		
	# of years used: Or year quit:		
Drugs	Do you currently use recreational or street drugs?	□ Yes	□ No
	Please check which street drugs you currently use or have used in the past:		
	□ Marijuana □ Cocaine / Crack □ Amphetamines □ LSD □ Mushrooms □ Heroin □ Other (__________________)		
	Have you ever given yourself street drugs with a needle?	□ Yes	□ No
Relationships / Sex	Are you currently married / divorced or in a relationship?	□ Yes	□ No
	Are you sexually active?	□ Yes	□ No
	If yes, do you use protection?	□ Yes	□ No
	Are you monogamous?	□ Yes	□ No
	Any history of having a sexually transmitted disease? (if so, please indicate:________________________)	□ Yes	□ No
	History of sexual, mental/emotional, physical abuse?	□ Yes	□ No

WOMEN ONLY
Age at onset of menstruation:
Date of last menstruation:
Period every _____ days

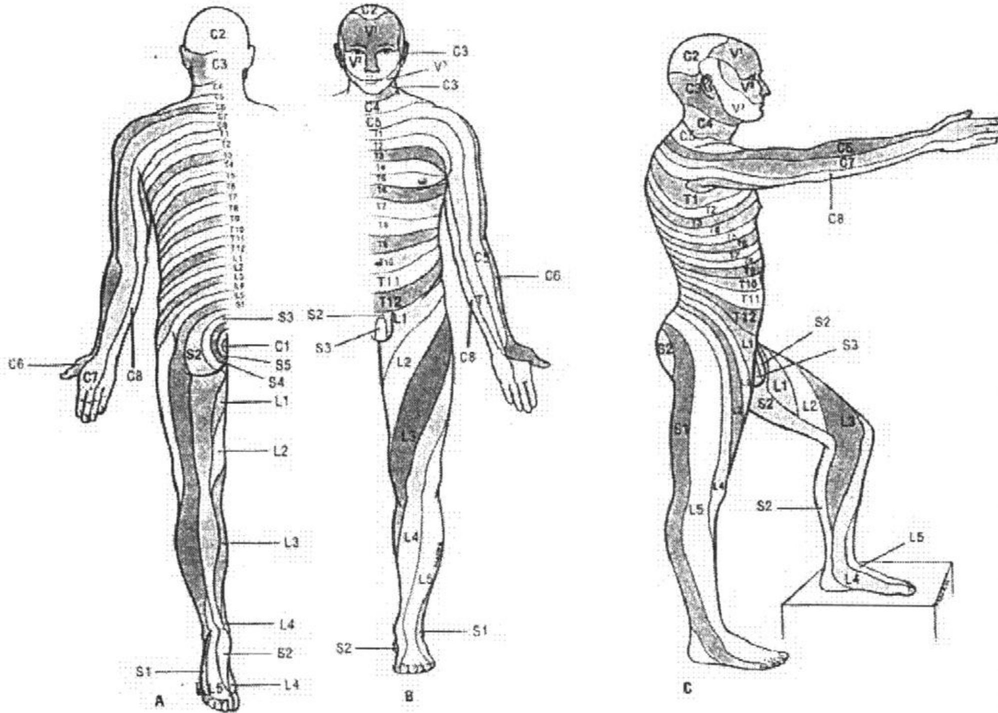
CONFIDENTIAL HEALTH HISTORY INTAKE

Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Experience bleeding between periods?	☐ Yes	☐ No
Experience painful intercourse?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine, current or past?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Experienced any vaginal discharge?	☐ Yes	☐ No
Abnormal Pap Smear or Mammogram? (please circle)	☐ Yes	☐ No
Date of last pap smear: ________________		
Date of last mammogram: ________________		

MEN ONLY		
Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate exam: ________________		

Do you experience pain? If so please mark on the figure where you experience pain and when did you first noticed the pain?

CONFIDENTIAL HEALTH HISTORY INTAKE



How committed are you towards making valuable changes?

Is there anything else you would like to mention?

I have never been the same since ____

<u>Please indicate if you have, have ever or never have experienced any of the following symptoms, by marking an X in the appropriate column</u>

	Yes Now	Yes Past	No	Comments
EYES				
Cataracts	____	____	____	____________
Double vision	____	____	____	____________
Do you wear glasses or contact lenses? (circle)	____	____	____	____________
Itching, burning, or watering of eyes?	____	____	____	____________
Loss of vision	____	____	____	____________
Eye pain	____	____	____	____________
Eye discharge	____	____	____	____________
Color blindness	____	____	____	____________
History of retinal detachment/surgery	____	____	____	____________
Date of last vision examination	____	____	____	____________
EARS, NOSE & THROAT				
Recurrent ears, nose or throat infections (circle)	____	____	____	____________
Frequent nose bleeds	____	____	____	____________
Loud snoring problem	____	____	____	____________
Sleep apnea	____	____	____	____________
Nocturnal CPAP	____	____	____	____________
Loss of hearing	____	____	____	____________
Buzzing or ringing in the ears	____	____	____	____________
Thyroid enlargement	____	____	____	____________
Recurrent hoarseness of voice	____	____	____	____________

Neck pain or neck lumps ____ ____ ____ ______________
Nasal allergies ____ ____ ____ ______________
Ear discharge or bleeding ____ ____ ____ ______________
History of sore throats ____ ____ ____ ______________
Difficulty swallowing ____ ____ ____ ______________
Impaired smell or taste ____ ____ ____ ______________
Nasal lesions or discharge ____ ____ ____ ______________
Sinus disease ____ ____ ____ ______________
Last hearing examination ____ ____ ____ ______________

MOUTH

Recurrent dental problems ____ ____ ____ ______________
Sore tongue ____ ____ ____ ______________
Do you have dentures or bridges? (circle) ____ ____ ____ ______________
Bleeding gums ____ ____ ____ ______________
Teeth, gum or oral lesions ____ ____ ____ ______________
Do you take antibiotics for dental procedures? ____ ____ ____ ______________
Last dental examination ____ ____ ____ ______________

RESPIRATORY

Severe shortness of breath or wheezing ____ ____ ____ ______________
Had cough for more then 1 month ____ ____ ____ ______________
Chest pain when cough hard or take deep breath ____ ____ ____ ______________
Cough up blood ____ ____ ____ ______________
Blood clots in lungs ____ ____ ____ ______________
Difficult breathing other then upright position ____ ____ ____ ______________
Shortness of breath when exertion or at night ____ ____ ____ ______________
Reduced exercise tolerance ____ ____ ____ ______________
Daily sputum production? color? ____ ____ ____ ______________

Yes Now | Yes Past | No | Comments

Last pulmonary function test ____ ____ ____ ______________
Last chest x-ray ____ ____ ____ ______________

BREAST

Nipple discharge ____ ____ ____ ______________
Breast pain, tenderness, or swelling ____ ____ ____ ______________
Breast mass ____ ____ ____ ______________
History of breast feeding ____ ____ ____ ______________
History of breast infection or trauma ____ ____ ____ ______________
Monthly self breast examinations ____ ____ ____ ______________
Last physician breast examination ____ ____ ____ ______________
Do you know how to examine your breasts? Yes _____, No _____
If not, would you like to be taught? Yes _____, No _____

CARDIOVASCULAR

Pain in the front of the chest (under sternum) ____ ____ ____ ______________
that is heavy or pressure like? ____ ____ ____ ______________
that is sharp or knife like? ____ ____ ____ ______________
that is aggravated by exercise, stress, or anger? ____ ____ ____ ______________
that improves with rest or Nitro? ____ ____ ____ ______________
Abnormal heart beat - skipped or extra beats ____ ____ ____ ______________
Very rapid unexplained heart beats ____ ____ ____ ______________
Excessive fluid retention/ankle swelling ____ ____ ____ ______________
Impaired circulation to the legs:

	Yes Now	Yes Past	No	Comments
arterial, venous (circle)				
Varicose veins				
Phlebitis (inflammation of veins)				
Poor healing leg sores				
Smothering spells relieved by sitting up				
Difficulty breathing at night				
Blood clots (deep vein thrombosis)				
Leg pain walking or at rest				
Color changes on fingers and/or toes				
Congenital heart defects				
Enlarged heart or abnormal heart				

Last echocardiogram______________________ performed by/at: ______________________

Last stress test ______________________ performed by/at: ______________________

Last cardiac catherization ______________________ performed by/at: ______________________

GASTROINTESTINAL

	Yes Now	Yes Past	No	Comments
Recurrent indigestion, heartburn, or a sense of food regurgitation (reflux)				
Difficulty swallowing				
Recurrent abdominal pain				
Frequent episodes of pressure or discomfort in the upper right side of the abdomen				
Major changes in the size or bowel movements				
Constipation for more than 1 month				
Diarrhea for more than 1 month				
Bright red blood on toilet paper or in toilet bowl				
Blood mixed in with stools				
Dark blood or black stools				
Positive stools for occult blood				
Irritable bowel or spastic colon				
Excessive belching or passing of gas				
History of hemorrhoids				
Vomiting blood				
Nausea or vomiting (circle)				
Loss of appetite				
Food intolerance				
Abnormal swelling				
Last upper GI (stomach x-ray)				
Last lower GI (barium enema x-ray)				

UROLOGICAL

	Yes Now	Yes Past	No	Comments
Bladder or kidney infections (circle)				
Painful urination or burning				
Blood in your urine or pus in your urine (circle)				
Problems starting to urinate				
Impaired, weakened urine stream				
Dribbling urine after you think you're finished				
Incontinence/leakage of urine (circle)				
History of herpes, venereal warts, HIV, or other sexually transmitted disease (circle)				
Urinating more than once during the night				
Bed wetting				
Urinary frequency				

Last IVP/kidney x-ray	____	____	____	____________________
Last PSA level	____	____	____	____________________

GENITOURINARY/REPRODUCTIVE

MEN ONLY

Pain or lumps in thes testicles	____	____	____	____________________
Problems initiating or maintaining an erection	____	____	____	____________________
Do you examine your testicles once per month?	____	____	____	____________________
Recurrent discharge at the end of the penis	____	____	____	____________________
Is there a history of sexual abuse?	____	____	____	____________________
Change in sexual activity	____	____	____	____________________

WOMEN ONLY

Your age at very first menstrual cycle ______________________________

Date of last period ____________________ Age of menopause ____________________

Age at the time of your first pregnancy? ______________________________

How many times have you been pregnant? ______________________________

Number of full term pregnancies ______________________________

Number of stillbirths/abortions ______________________________

Number of premature births ______________________________

Number of living children (twins?) ______________________________

Are you pregnant now? Yes _____, No _____

Are you having irregualr periods? Yes _____, No _____

Do you have heavy or prolonged periods or pass clots? Yes _____, No _____

Do you have severe cramps or pain? Yes _____, No _____

Do you have spotting or bleeding between normal menses? Yes _____, No _____

Do you use birth control medication or devices? Yes _____, No _____

If so, what kind? ______________________________

Have you ever had a cervical or uterine biopsy? Yes _____, No _____

When ____________________ Results ______________________________

Are you on hormone replacement therapy? Yes _____, No _____

If yes, date started ______________________________

Date of last pelvic examination and Pap smear ______________ Results: ____________________

	Yes Now	Yes Past	No	Comments
MUSCULOSKELETAL				
Bursitis or tendonitis (circle)	____	____	____	____________________
Broken bones (fractures) - where?	____	____	____	____________________
Major joint injuries in knee or shoulder (circle)	____	____	____	____________________
Any artificial joints (prosthesis) (hip, knee, digits) (circle)	____	____	____	____________________
Chronic back pain	____	____	____	____________________
Muscle pain	____	____	____	____________________
Muscle weakness	____	____	____	____________________
Limitations on walking or running	____	____	____	____________________
Joint stiffness/pain	____	____	____	____________________
Amputations (location)	____	____	____	____________________
LYMPHATIC/INFECTIOUS, IMMUNOLOGIC DISEASES				
History of chronic infections/ swollen lymph nodes/glands	____	____	____	____________________
Measles	____	____	____	____________________
Mumps	____	____	____	____________________

	Yes Now	Yes Past	No	Comments
Chickenpox				
Rheumatic fever				
Scarlet fever				
HIV positive				
Tuberculosis/positive skin test				

Immunizations: Vaccines/Dates

- Tetanus ____________________
- Hepatitis ____________________
- Influenza ____________________
- Pneumonia ____________________
- Diptheria ____________________

NEUROLOGICAL

	Yes Now	Yes Past	No	Comments
Migraine headaches				
Tension/stress headaches				
Recurrent or persistent dizziness (vertigo)				
Recurrent episodes of weakness, numbness, pain in one leg, foot, arm or hand (where?)				
Paralysis				
Recurrent tremor or twitches				
Problems with reading or memory				
Loss of consciousness				
Abnormal nerve pain				
Speech or language dysfunction				
Loss of balance				

SKIN/GENERAL

	Yes Now	Yes Past	No	Comments
History of skin cancer / type? / location?				
Persistent or recurrent skin rashes (where?)				
Delayed healing of skin ulcers or sores				
Unexplained itching or hives				
Excessive dry skin or scaling				
Change in a mole or birth mark / location?				
Change in hair or nails - describe				
Fatigue				
Fever or chils (circle)				

HEMATOLOGY/ONCOLOGY

	Yes Now	Yes Past	No	Comments
Anemia / low blood count				
Tendency for bleeding or severe bruising				
Clotting disorder				
Lymphoma / lymph node cancer				
Leukemia / blood cancer				
Low platelet count				

ENDOCRINE

	Yes Now	Yes Past	No	Comments
Borderline blood sugars high / low (circle)				
Calcium problems				
Thyroid nodule / cyst (circle)				
Adrenal or pituitary gland problems (circle)				

Unexplained changes in height and weight ____ ____ ____ ____________________
Heat or cold intolerance (circle) ____ ____ ____ ____________________
Changes in hair distribution or skin pigmentation (describe) ____ ____ ____ ____________________
Last thyroid profile (blood tests) ____ ____ ____ ____________________
Last thyroid scan, uptake and ultrasound ____ ____ ____ ____________________

PSYCHIATRIC

Nervous or emotional problems ____ ____ ____ ____________________
Have you been under the care of psychiatrist or psychologist? ____ ____ ____ ____________________
Anxiety ____ ____ ____ ____________________
Depression ____ ____ ____ ____________________
Loss of interest in your normal or fun activities ____ ____ ____ ____________________
Do you feel inadequately refreshed after a night's sleep? ____ ____ ____ ____________________
Problems falling asleep ____ ____ ____ ____________________
Problems maintaining sleep once you have fallen asleep ____ ____ ____ ____________________
Loss of sexual desire ____ ____ ____ ____________________
Thoughts of worthlessness or hopelessness ____ ____ ____ ____________________
Do you find it hard to concentrate, make decisions, remember details, or get things done? ____ ____ ____ ____________________
Do you have suicidal thoughts or plans? ____ ____ ____ ____________________
In the past year, has a family member or close relative died? ____ ____ ____ ____________________
Do you have panic attacks? ____ ____ ____ ____________________

Please indicate 0-10, with 10 being the most happy and content, how positive you feel about:

Love and Romance ______	Career & Power ______	Health & Fitness ______	Money & Financial Success_____
Environment & Health Connection ______	Personal Growth & Spirituality ______	Fun & Recreation ______	Family & friends ______

Please circle one number per question for the questions below: 0 being condition does not exist, 10 being worst effect on you have ever experienced.

How limited your activity is as a result of fatigue: 0 1 2 3 4 5 6 7 8 9 10

Do you experience anxiety or depression: 0 1 2 3 4 5 6 7 8 9 10

How difficult is it for you to sleep or stay asleep: 0 1 2 3 4 5 6 7 8 9 10

Do you have night sweats: 0 1 2 3 4 5 6 7 8 9 10

Do you have day sweats: 0 1 2 3 4 5 6 7 8 9 10

How limited your physical activity is as a result of pain: 0 1 2 3 4 5 6 7 8 9 10

CONFIDENTIAL HEALTH HISTORY INTAKE

Do you currently experience pain? _________ If yes, circle the kind of pain you have:

Dull Sharp Stabbing Radiating Shooting Throbbing Hot Cold

Where is your pain:

____

____

Please feel free to expand on any concerns you think are important/relevant to your health.____

____

____

____

____

____

____

Please check off the Vegetables, Fruits, & Proteins you WILL NOT or CANNOT eat

Vegetable List

	Alfalfa Sprouts
	Artichoke
	Arugula
	Asparagus
	Beans (black, lima, etc.)
	Beets
	Black eyed peas
	Broccoli
	Brussels sprouts
	Cabbage
	Carrots
	Cauliflower
	Celery
	Chard
	Chives
	Collard greens
	Corn
	Cucumber
	Eggplant
	Endive
	Fennel
	Garlic
	Ginger

	Green beans
	Kale
	Kelp
	Leeks
	Lentils
	Lettuce (romaine, baby greens, etc.)
	Mushrooms
	Mustard greens
	Okra
	Onions
	Parsley
	Parsnips
	Peas
	Peppers (red or green)
	Potato
	Pumpkin
	Radicchio
	Radishes
	Rhubarb
	Rutabaga
	Spinach
	Squash
	Sweet Potato

	Tomato
	Turnips
	Water chestnuts

	Yams
	Zucchini

Fruit List

	Apple
	Apricots
	Avocado
	Banana
	Blackberries
	Blueberries
	Boysenberries
	Cantaloupe
	Cherries
	Crabapples
	Cranberries
	Dates
	Figs

	Grapefruit
	Grapes
	Guava
	Honeydew
	Kiwi
	Lemon
	Lime
	Mandarin
	Mango
	Nectarine
	Orange
	Papaya
	Passionfruit

	Peach
	Pear
	Persimmon
	Pineapple
	Plum
	Pomegranate
	Prunes
	Raisins
	Raspberries
	Strawberries
	Tangerine
	Watermelon

Proteins

Meats:

	Chicken
	Ham
	Beef
	Pork

Fish & Seafood:

	Salmon
	Tuna
	Cod
	Grouper
	Sea Bass
	Snapper
	Herring
	Mackerel
	Crab
	Lobster
	Shrimp
	Mussels
	Oysters

Dairy

	Eggs
	Cheese
	Yogurt
	Cottage Cheese
	Whey Protein Powder

Nuts:

	Almonds
	Walnuts
	Brazilnuts
	Cashews
	Hazelnuts
	Macadamia Nuts
	Pecans
	Pistachio
	Almond Butter
	Cashew Butter
	Sesame Butter
	Natural Peanut Butter

AMS Questionnaire

Patient Name: ______________________________ **Age:**_______ **Date:**____/____/_____

Which of the following symptoms apply to you at this time? Please, mark the appropriate box for each symptom. For symptoms that do not apply, please mark "none"

Symptoms:

Please answer questions based on current symptoms today.

	Symptom	none	mild	moderate	severe	extremely severe
	Score =	1	2	3	4	5
1.	**Decline in your feeling of general well being** (general state of health, subjective feeling)........	☐	☐	☐	☐	☐
2.	**Joint pain and muscluar ache** (lower back pain, joint pain, pain in a limb, back ache)........	☐	☐	☐	☐	☐
3.	**Excessive sweating** (unexpected/sudden episodes of sweating, hot flushes, independent of strain)........	☐	☐	☐	☐	☐
4.	**Sleep Problems** (difficulty in falling asleep, difficulty in sleeping through, waking up early/feeling tired, poor sleep, sleeplessness)........	☐	☐	☐	☐	☐
5.	**Increased need for sleep, often feeling tired**........	☐	☐	☐	☐	☐
6.	**Irritability** (feeling aggressive, easily upset about little things, moody)........	☐	☐	☐	☐	☐
7.	**Nervousness** (inner tension, restlessness, feeling fidgety)........	☐	☐	☐	☐	☐
8.	**Anxiety** (feeling panicky)........	☐	☐	☐	☐	☐
9.	**Physical exhaustion/lacking vitality** (general decrease in performance, reduced activity, lacking interest in leisure, feeling of getting less done, having to force oneself to perform activities)........	☐	☐	☐	☐	☐
10.	**Decrease in muscular strength** (feeling of weakness)........	☐	☐	☐	☐	☐
11.	**Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings, feeling nothing is of any use)........	☐	☐	☐	☐	☐
12.	**Feeling that you have passed your peak**........					
13.	**Feeling burnt out, having hit rock-bottom**........	☐	☐	☐	☐	☐
14.	**Decrease in beard growth**........	☐	☐	☐	☐	☐
15.	**Decrease in ability/frequency to perform sexually**........	☐	☐	☐	☐	☐
16.	**Decrease in the number of morning erections**........	☐	☐	☐	☐	☐
17.	**Decrease in sexual desire/libido** (lacking pleasure in sex, lacking desire for sexual intercourse)........	☐	☐	☐	☐	☐

Do you have any other major symptoms? **Yes......☐** **No......☐**

If Yes, please describe: ____

____

18. **Date of last T-cyp injection:** ____/____/_____ **# of Days since last Injection:**________
19. **Date of last HCG injection:** ____/____/_____ **# of Days since last Injection:**________
20. **Time T-Cream was applied today** _____:_____**am/pm** **# of Days Consistent:**________

21. **Have you ejaculated in the last 48hrs:** **Yes....☐** **No.....☐**
22. **Have you rode a motorcycle or bicycle in the last 48hrs?** **Yes....☐** **No.....☐**
23. **What days do you take testosterone/hcg injections?** M___ Tu___ Wed___ Th___ Fri___ Sat___ Sun___
*(mark Testosterone days with **T.** HCG days with **H)***

THYROID TRACKING SHEET

NAME: ______________________________ **Date:** ____________

In the spaces provided please rate your current symptoms on the following scale:

0= No symptoms

1= Symptoms are Mild

2= Symptoms are Mild to Moderate

3= Symptoms are Moderate

4= Moderately Severe

5= Severe/ Frequent Symptoms

Question	Rating
Do you have fatigue?	______
Do you have elevated cholesterol?	______
Do you have difficulty losing weight?	______
Do you have cold hands and feet?	______
Are you sensitive to the cold?	______
Do you have difficulty thinking or concentrating?	______
	0
Do you experience brain fog or short term memory?	______
	0
Are your moods depressed?	______
Are you experiencing hair loss?	______
Are you tired when you awaken?	______
Do you have dry skin?	______
	0
Do you have fluid retention?	______
Do you have recurrent headaches?	______
Do you sleep restlessly?	Yes or No
Do you have afternoon fatigue?	______
Do you experience tingling or numbness in your hands or feet?	______
Do you have decreased sweating?	______
Have you had problems with infertility or miscarriages?	Yes or No
Do you have recurrent infections?	______
Do your muscles ache?	______
	0
Do you have thinning of your eyebrows or eyelashes?	______
	0
Is your skin pasty, puffy or pale?	______
	0
Is your voice hoarse?	______
	0
Do you have low blood pressure?	______
	0
Do you have sleep apnea?	______

Current Medication Name & Strength: ______________________________

Current Medication Name & Strength: ______________________________

Current Medication Name & Strength: ______________________________