

**THE WOODLANDS INSTITUTE FOR HEALTH & WELLNESS**  
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Name: \_\_\_\_\_

**REVIEW OF SYMPTOMS**

**Lifetime Antibiotic Use:**

How many times have you used antibiotics over the past year? \_\_\_\_\_  
20 years? \_\_\_\_\_

**Allergy Treatment:**

Have you ever been evaluated by an allergist? \_\_\_\_\_  
If so, what year? \_\_\_\_\_  
Did you ever receive allergy shots? \_\_\_\_\_

**Headaches:**

Do you have headaches? \_\_\_\_\_ How many per wk? \_\_\_\_\_  
For how many years? \_\_\_\_\_  
What do you take to relieve them? \_\_\_\_\_

**Nose/Eyes:**

Do you have sinus problems? \_\_\_\_\_  
Do you snore? \_\_\_\_\_  
Do you have post nasal drainage (PND)? \_\_\_\_\_  
Do you have an itchy nose or eyes? \_\_\_\_\_  
Do you sneeze often? \_\_\_\_\_  
Is it worse when exposed to smoke or dust? \_\_\_\_\_  
Do you have sinus infections? \_\_\_\_\_ How many x/year? \_\_\_\_\_  
Do you have a poor/decreased sense of smell? \_\_\_\_\_

**Ears:**

Do you have ear infections? \_\_\_\_\_ How many times per year? \_\_\_\_\_  
Do you have poor/decreased hearing? \_\_\_\_\_  
Do you have dizziness or lightheadedness? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you have ringing in the ears? \_\_\_\_\_

**Mouth:**

Do you develop canker sores? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you develop fever blisters? \_\_\_\_\_ How often? \_\_\_\_\_  
Have you had any wisdom teeth extracted? \_\_\_\_\_  
Have you had any other teeth extracted? \_\_\_\_\_  
Do you have mercury amalgam fillings in your mouth? \_\_\_\_\_  
Have you ever had a root canal? \_\_\_\_\_

**Throat:**

Do you have sore throats? \_\_\_\_\_ How often? \_\_\_\_\_  
Have you ever had strep throat? \_\_\_\_\_ How many times? \_\_\_\_\_  
Do you have difficulty swallowing on a regular basis? \_\_\_\_\_ For how many years? \_\_\_\_\_

**Lungs:**

Do you experience chest congestion and cough? \_\_\_\_\_ How often? \_\_\_\_\_  
Have you ever had bronchitis? \_\_\_\_\_ How often? \_\_\_\_\_

**Asthma:**

Do you have asthma? \_\_\_\_\_ How many x/year? \_\_\_\_\_

Do you have wheezing? \_\_\_\_\_ Seasonally or year round? \_\_\_\_\_ For how many years? \_\_\_\_\_  
How often? \_\_\_\_\_ For how many years? \_\_\_\_\_  
Do you generally feel short of breath? \_\_\_\_\_ For how many years? \_\_\_\_\_

**Food History:**

Do you consume caffeinated beverages? \_\_\_\_\_ How many per day? \_\_\_\_\_  
Do you consume alcoholic beverages? \_\_\_\_\_ How many per day? \_\_\_\_\_  
Do you crave sweets, breads or salty foods? \_\_\_\_\_

Are there any foods that you have an adverse reaction to?

List food and symptoms:

Foods	Symptoms
_____	_____
_____	_____
_____	_____
_____	_____

Please describe a TYPICAL:

breakfast \_\_\_\_\_  
lunch \_\_\_\_\_  
dinner \_\_\_\_\_  
snack \_\_\_\_\_

**Heart:**

Do you ever feel your heart skip a beat? \_\_\_\_\_ How often? \_\_\_\_\_  
For how many years? \_\_\_\_\_  
Do you ever have chest pain? \_\_\_\_\_ How often? \_\_\_\_\_  
For how many years? \_\_\_\_\_  
Is the pain sharp, stabbing, dull, or aching? \_\_\_\_\_  
Does it radiate to your neck, back, or shoulders? \_\_\_\_\_  
How long does the pain last? \_\_\_\_\_  
Do you ever feel like you are going to pass out? \_\_\_\_\_

**Gastrointestinal System:**

Do you have indigestion or heartburn? \_\_\_\_\_ How often? \_\_\_\_\_  
For how many years? \_\_\_\_\_  
Do you experience abdominal cramping or bloating? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you experience excessive belching or gas? \_\_\_\_\_ How often? \_\_\_\_\_  
Have you ever had bright red blood in your stools? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you have diarrhea often? \_\_\_\_\_ How often? \_\_\_\_\_  
How many times per week do you have a bowel movement? \_\_\_\_\_  
Do you alternate between constipation and diarrhea? \_\_\_\_\_

**Urinary Tract:**

Have you ever had bladder infections? \_\_\_\_\_ How often? \_\_\_\_\_  
Have you ever had kidney infections? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you have burning upon urination? \_\_\_\_\_  
Do you have increased frequency of urination? \_\_\_\_\_

**Yeast/Skin Fungus:**

Do you have problems with athlete's foot? \_\_\_\_\_  
Are your toenails discolored or unusually thickened? \_\_\_\_\_  
Have you ever had a vaginal yeast infection? \_\_\_\_\_ How many times? \_\_\_\_\_  
Were your yeast infections associated with antibiotic use? \_\_\_\_\_

**Skin:**

Do you have eczema or skin rashes? \_\_\_\_\_  
Location: \_\_\_\_\_  
Do you know the cause of your rashes? \_\_\_\_\_

Have you ever had hives? \_\_\_\_\_  
Do you know the cause of your hives? \_\_\_\_\_  
Do you have dry and/or itchy skin? \_\_\_\_\_

**Thyroid:**

Have you ever been diagnosed with a thyroid disorder? \_\_\_\_\_ Year diagnosed \_\_\_\_\_  
Were you diagnosed with hyperthyroidism (high) or hypothyroidism (low)? \_\_\_\_\_

**Malaise/Fatigue:**

Do you feel you should have more energy? \_\_\_\_\_  
What is your **average** energy level on a scale of 1 to 10 with 10 meaning brimming with energy and 1 meaning the inability to get out of bed?  
ENERGY LEVEL 1 - 10 \_\_\_\_\_ /10 For how many years? \_\_\_\_\_

**Fluid Retention:**

Do you have swelling beneath your eyes or dark circles under your eyes? \_\_\_\_\_  
Do you ever have swelling of your face, hands, or feet? \_\_\_\_\_ How often? \_\_\_\_\_

**Cold Sensitivity:**

Do you have cold hands or feet? \_\_\_\_\_  
Are you sensitive to the cold or get chilled easily? \_\_\_\_\_

**Sweating:**

Do the palms of your hands or feet perspire excessively? \_\_\_\_\_  
Do you have decreased perspiration? \_\_\_\_\_

**Hair Condition:**

Do you have coarse or fine hair? \_\_\_\_\_  
Have you ever had significant hair loss? \_\_\_\_\_

**Weight:**

Have you had significant weight gain? \_\_\_\_\_ How many pounds? \_\_\_\_\_  
Since what year? \_\_\_\_\_  
Do you have difficulty losing weight? \_\_\_\_\_ For how many years? \_\_\_\_\_

**Cognitive Ability:**

Do you ever feel that you have decreased mental sharpness? \_\_\_\_\_  
Do you have a poor short-term memory? \_\_\_\_\_

**Mood:**

Do you ever feel discouraged, blue or depressed? \_\_\_\_\_  
What percent of the time? \_\_\_\_\_ % For how many years? \_\_\_\_\_  
Have you ever taken anti-depressants? \_\_\_\_\_  
Which one(s)? \_\_\_\_\_  
Between what ages? \_\_\_\_\_ and \_\_\_\_\_

**Joint Function:**

Do you have pain in any joint(s)? \_\_\_\_\_ Which of the following joints?  
\_\_\_\_\_ Neck \_\_\_\_\_ Shoulder  
\_\_\_\_\_ Wrists \_\_\_\_\_ Hips  
\_\_\_\_\_ Ankles \_\_\_\_\_ Elbows  
\_\_\_\_\_ Lower Back \_\_\_\_\_ Knees  
\_\_\_\_\_ Finger joints \_\_\_\_\_ Toe joints  
How many times per week? \_\_\_\_\_ For how many years? \_\_\_\_\_

**Muscle:**

Do you ever have numbness or tingling in the extremities? \_\_\_\_\_  
Which ones? \_\_\_\_\_  
Do you have muscle weakness? \_\_\_\_\_  
Do you ever have diffuse muscle aches? \_\_\_\_\_  
Do you ever have cramping in your muscles? \_\_\_\_\_ For how many years? \_\_\_\_\_  
Which muscles? \_\_\_\_\_ Thighs? \_\_\_\_\_ Calves? \_\_\_\_\_ Feet? \_\_\_\_\_

**Sleep:**

Do you have insomnia or restless sleep? \_\_\_\_\_ For how many years? \_\_\_\_\_

**Menstrual History - Postmenopausal Questions**

**Pregnancy:**

Date of last normal menstrual period? \_\_\_\_\_ At what age did you enter puberty? \_\_\_\_\_  
How many pregnancies? live births? \_\_\_\_\_ miscarriages? \_\_\_\_\_ terminations? \_\_\_\_\_  
Your age at the time of first child: \_\_\_\_\_ Did you have trouble getting pregnant? \_\_\_\_\_  
Did you ever receive infertility treatment? \_\_\_\_\_ What kind? \_\_\_\_\_

**Hysterectomy:**

Have you had a hysterectomy? \_\_\_\_\_  
Reason? \_\_\_\_\_ Year? \_\_\_\_\_  
Were both of your ovaries removed at the time of your hysterectomy? \_\_\_\_\_  
If not, have both of your ovaries been removed since then? \_\_\_\_\_ Year? \_\_\_\_\_  
Reason? \_\_\_\_\_  
Have you ever taken progesterone or estrogen? \_\_\_\_\_  
If yes, which ones? \_\_\_\_\_  
For how many years? \_\_\_\_\_

**Birth Control:**

Did you ever take Depo Provera or birth control pills? \_\_\_\_\_  
If yes, for how long? \_\_\_\_\_ years  
Date you discontinued (year): \_\_\_\_\_

**Pap Smear:**

Have you ever had an **abnormal** pap smear? \_\_\_\_\_ If yes, when? (mo/yr) \_\_\_\_\_  
Was your most recent pap smear normal? \_\_\_\_\_ Date (mo/yr) \_\_\_\_\_

**Menstrual Periods:**

Did your menstrual periods occur at the same time each month? \_\_\_\_\_  
If no, what was the shortest number of days between periods? \_\_\_\_\_ days  
What was the longest number of days between periods? \_\_\_\_\_ days  
How many days did your periods last? \_\_\_\_\_ days  
How long were your menstrual cycles irregular? \_\_\_\_\_ years  
Were your menstrual cycles ever regular? \_\_\_\_\_  
Prior to your hysterectomy or menopause did your periods become heavier? \_\_\_\_\_  
Prior to your hysterectomy or menopause did your periods become lighter? \_\_\_\_\_  
Did you have spotting/bleeding between your normal periods? \_\_\_\_\_

**Estrogen Dominance:**

Do you have fibrocystic breast disease? \_\_\_\_\_  
Did you have endometriosis? \_\_\_\_\_  
Did you have uterine fibroids? \_\_\_\_\_  
Did you have ovarian cysts? \_\_\_\_\_  
Have you developed dark hair on your face or breasts? \_\_\_\_\_  
Do you have hot flashes? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you have night sweats? \_\_\_\_\_ How often? \_\_\_\_\_  
Have you had a decrease in your sexual desire? \_\_\_\_\_ For how long? (mos/yrs) \_\_\_\_\_  
Do you have painful intercourse? \_\_\_\_\_

**Breasts:**

Date of last mammogram? \_\_\_\_\_  
Where was it performed, or which doctor prescribed it? \_\_\_\_\_  
Phone number for facility or doctor? \_\_\_\_\_  
Was your last mammogram normal? \_\_\_\_\_  
If no, what were the findings? \_\_\_\_\_  
Have you ever had abnormal discharge form your breasts? \_\_\_\_\_  
If yes, what color? \_\_\_\_\_

Have you had a breast biopsy? \_\_\_\_\_  
 Have you had your breast(s) aspirated? \_\_\_\_\_  
 Do you have breast implants? \_\_\_\_\_

How many times? \_\_\_\_\_  
 How many times? \_\_\_\_\_  
 What kind? (saline/silicone) \_\_\_\_\_

**Current Medications:**

Do you currently take any medications? (Include prescription, over-the-counter, vitamins, supps)  
 Please list the medication, strength, times/day taken and number of years taken:

- 1 \_\_\_\_\_
- 2 \_\_\_\_\_
- 3 \_\_\_\_\_
- 4 \_\_\_\_\_
- 5 \_\_\_\_\_
- 6 \_\_\_\_\_
- 7 \_\_\_\_\_

**Past Medical History:**

<u>Yes/No</u>	<u>Illnesses</u>	<u>Year</u>	<u>Type:</u> _____
_____	Cancer	_____	
_____	Chronic Fatigue Syndrome	_____	
_____	Colitis	_____	
_____	Diabetes	_____	
_____	Elevated Cholesterol	_____	
_____	Elevated Triglycerides	_____	
_____	Fibromyalgia	_____	
_____	Gall Bladder Disease	_____	
_____	Heart Disease	_____	
_____	Hepatitis	_____	
_____	HIV	_____	
_____	Hypertension	_____	
_____	Hyperthyroidism	_____	
_____	Hypothyroidism	_____	
_____	Irritable Bowel Syndrome	_____	
_____	Kidney Disease	_____	
_____	Lupus	_____	
_____	Mitral Valve Prolapse	_____	
_____	Mononucleosis	_____	
_____	Multiple Sclerosis	_____	
_____	Oral Yeast/Mouth Infection	_____	
_____	Osteoporosis/Osteopenia	_____	
_____	Pelvic Inflammatory Disease	_____	
_____	Pneumonia	_____	
_____	Seizures	_____	
_____	Sexually Transmitted Disease	_____	Type: _____
_____	Sleep Apnea	_____	
_____	Stroke	_____	
_____	Tuberculosis	_____	
_____	Ulcerative Colitis	_____	

**Drug Allergies:**

(Please list all drug allergies, and what your reaction is to each medication)

- |   |       |   |       |
|---|-------|---|-------|
| 1 | _____ | 4 | _____ |
| 2 | _____ | 5 | _____ |
| 3 | _____ | 6 | _____ |

**Surgical Procedures:**

What surgeries have you had? \_\_\_\_\_ Year(s)

