

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 many x/year? _____
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? _____

Seasonally or year round? _____ For how many years? _____
Do you have wheezing? _____ 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? _____

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 often? _____ 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? _____
If so, which ones? _____

Sleep:

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

Menstrual History - Premenopausal 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? _____

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:

Do 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 do your periods last? _____ days
How long have your menstrual cycles been irregular? _____ months _____ years
Were your menstrual cycles ever regular? _____
Are your periods heavier or lighter than in the past? _____
If yes, when did they change? (month/year) _____
Do you have any bleeding/spotting between your normal periods? _____

Premenstrual Syndrome:

Do you have breast tenderness prior to your period? _____
If yes, how many days prior to your period does it begin? _____ days
Do you have mood swings prior to your period? _____
If yes, how many days prior to your period does it begin? _____ days
Do you have fluid retention prior to your period? _____
If yes, how many days prior to your period does it begin? _____ days
Do you have weight gain prior to your period? _____
Approximately how many pounds do you gain prior to your periods? _____ lbs.
Do you crave sweets, bread products, or salty foods prior to your periods? _____
Do you develop headaches (not migraine) prior to your periods? _____
If yes, how many days prior to your periods do they begin? _____ days
Do you ever have menstrual cramps or clotting? _____
If yes, for how many days? _____
Do you experience hot flashes or night sweats? _____

Estrogen Dominance:

Do you have fibrocystic breast disease? _____
Do you have endometriosis? _____
Do you have uterine fibroids? _____
Have you had ovarian cysts? _____
Have you developed dark hair on your face or breasts? _____
Have you had a decrease in your sexual desire? _____
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? _____ For how long? _____

Have you had a breast biopsy? _____ How many times? _____

Have you had your breast(s) aspirated? _____ How many times? _____

Do you have breast implants? _____ What kind? (saline/silicone) _____

If yes, when was the surgery performed? (mo/yr) _____

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:

	<u>What surgeries have you had?</u>	<u>Year(s)</u>
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____
5	_____	_____

Family History:

	<u>Age</u>	<u>Medical Problem(s)</u>
Father - alive or deceased?	_____	_____
Mother - alive or deceased?	_____	_____
Brothers/sisters:	_____	_____
	_____	_____
	_____	_____
	_____	_____

Social History:

Do you currently smoke? _____ Are you a former smoker? _____
How many packs per day? _____ How long? _____
What is your occupation? _____

Pets:

Do you have any pets? _____ Cat _____ Dog _____
Other _____
Are the pets indoor, outdoor, or both? _____

Chief Complaint:

What are your primary concerns? _____

