If you have had any of the following symptoms, check the box that tells us if the symptom was in the **Past** or if it is **Current**. Also circle one of the numbers to the right of the symptom.

Past	Current	Symptom	1=least severe 5=most severe	Past	Current	Symptom	1=least severe 5=most severe
☐	☐	Abdominal/Stomach pain	1 2 3 4 5	☐	☐	Frequent/extended hoarseness	1 2 3 4 5
☐	☐	Always hungry	1 2 3 4 5	☐	☐	Hearing difficulties	1 2 3 4 5
☐	☐	Black stools	1 2 3 4 5	☐	☐	Nose Bleeds	1 2 3 4 5
☐	☐	Constipation	1 2 3 4 5	☐	☐	Sinus Problems	1 2 3 4 5
☐	☐	Diarrhea	1 2 3 4 5	☐	☐	Sore Throats	1 2 3 4 5
☐	☐	Heartburn	1 2 3 4 5	☐	☐	Sounds/ringing in ears	1 2 3 4 5
☐	☐	Indigestion	1 2 3 4 5	☐	☐	Swollen glands	1 2 3 4 5
☐	☐	Gas	1 2 3 4 5	☐	☐	Trouble with your eyes	1 2 3 4 5
☐	☐	Lack of appetite	1 2 3 4 5	☐	☐	Unusual taste in mouth	1 2 3 4 5
☐	☐	Nausea	1 2 3 4 5	☐	☐	Dry skin	1 2 3 4 5
☐	☐	Overweight	1 2 3 4 5	☐	☐	Itching/burning skin	1 2 3 4 5
☐	☐	Unusually thirsty	1 2 3 4 5	☐	☐	Skin rash	1 2 3 4 5
☐	☐	Vomiting	1 2 3 4 5	☐	☐	Bloody urination	1 2 3 4 5
☐	☐	Weight changes	1 2 3 4 5	☐	☐	Burning urination	1 2 3 4 5
☐	☐	Bleeding easily	1 2 3 4 5	☐	☐	Difficult urination	1 2 3 4 5
☐	☐	Bleeding gums	1 2 3 4 5	☐	☐	Frequent urination	1 2 3 4 5
☐	☐	Bruising easily	1 2 3 4 5	☐	☐	Loss of bladder control	1 2 3 4 5
☐	☐	Chest pain/pressure	1 2 3 4 5	☐	☐	Painful urination	1 2 3 4 5
☐	☐	Dizzy spells/blackouts	1 2 3 4 5	☐	☐	Urination at night	1 2 3 4 5
☐	☐	Irregular heart beat	1 2 3 4 5	☐	☐	Concerns about sexual function	1 2 3 4 5

☐	☐	Poor circulation	1 2 3 4 5	☐	☐	Convulstions	1 2 3 4 5
☐	☐	Pounding heart beat	1 2 3 4 5	☐	☐	Depression	1 2 3 4 5
☐	☐	Racing heart beat	1 2 3 4 5	☐	☐	Fatigue/tiredness	1 2 3 4 5
☐	☐	Chest colds	1 2 3 4 5	☐	☐	Frequent/severe headache	1 2 3 4 5
☐	☐	Chronic cough	1 2 3 4 5	☐	☐	Difficulty getting to sleep	1 2 3 4 5
☐	☐	Congested nose	1 2 3 4 5	☐	☐	Difficulty staying asleep	1 2 3 4 5
☐	☐	Coughing up blood	1 2 3 4 5	☐	☐	Leg cramps	1 2 3 4 5
☐	☐	Smoking	1 2 3 4 5	☐	☐	Nervousness	1 2 3 4 5
☐	☐	Sneezing	1 2 3 4 5	☐	☐	Numbness/tingling	1 2 3 4 5
☐	☐	Wheezing	1 2 3 4 5	☐	☐	Shaking/trembling	1 2 3 4 5
☐	☐	Chills	1 2 3 4 5	☐	☐	Stuttering/stammering	1 2 3 4 5
☐	☐	Excessive sweating	1 2 3 4 5	☐	☐	Back trouble	1 2 3 4 5
☐	☐	Fever	1 2 3 4 5	☐	☐	Pain/swelling - any joint	1 2 3 4 5
☐	☐	Lack of perspiration	1 2 3 4 5	☐	☐	Painful feet	1 2 3 4 5
☐	☐	Night sweats	1 2 3 4 5	☐	☐	Painful muscles	1 2 3 4 5
☐	☐	Tendency to be too cold	1 2 3 4 5	☐	☐	Stiff or painful neck	1 2 3 4 5
☐	☐	Tendency to be too hot	1 2 3 4 5	☐	☐	Swelling of feet/legs	1 2 3 4 5
☐	☐	Earaches	1 2 3 4 5	☐	☐		1 2 3 4 5

Other specific symptoms or illnesses you have had:

Please list all surgeries & hospitalizations you have had: