From the office of:
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GENERAL INFORMATION

Name	*First*	*Middle*	*Last*	
Preferred Name				
Date of Birth				
Age				
Gender	☐ Male	☐ Female		
Genetic Background	☐ African	☐ European	☐ Native American	☐ Mediterranean
	☐ Asian	☐ Ashkenazi	☐ Middle Eastern	☐
Highest Education Level				
Job Title				
Nature of Business				
Primary Address	*Number, Street*			*Apt. No.*
	City		*State*	*Zip*
Alternate Address	*Number, Street*			*Apt. No.*
	City		*State*	*Zip*
Home Phone 1				
Home Phone 2				
Work Phone				
Cell Phone				
Fax				
Email				
Emergency Contact	*Name*		*Phone Number*	
	Address			*Apt. No.*
	City		*State*	*Zip*
Physician	*Name*		*Phone Number*	
	Fax			
Referred by	☐ Book	☐ Website		
	☐ Media	☐ Friend or Family Member	☐ Other	

Sound Integrative Health

Name _____

Date _____

Date of Birth _____

Medical Questionnaire

ALLERGIES

Medication/Supplement/Food	Reaction

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us? _____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success: Excellent	Good	Fair
Example: Post Nasal Drip		*X*		*Elimination Diet*	*X*		

Initials _____

PHARMACY INFORMATION

Primary Pharmacy

Name _____ *Phone Number* _____

Address _____

City _____ *State* _____ *Zip* _____

Email _____ **Fax*** _____

It is extremely important that you list the pharmacy's fax number.

Compounding/ Supplement Pharmacy

Name _____ *Phone Number* _____

Address _____

City _____ *State* _____ *Zip* _____

Email _____ **Fax*** _____

It is extremely important that you list the pharmacy's fax number.

GYNECOLOGIC HISTORY *(for women only)*

OBSTETRIC HISTORY *Check box if yes and provide number of*

☐ Pregnancies _____ ☐ Caesarean _____ ☐ Vaginal Deliveries _____

☐ Miscarriage _____ ☐ Abortion _____ ☐ Living Children _____

☐ Post-Partum Depression ☐ Toxemia ☐ Gestational Diabetes ☐ Baby Over 8 Pounds

☐ Breast Feeding For how long? _____

MENSTRUAL HISTORY

Age at First Period: ____ Menses Frequency: _____ Length: _____ Pain: ☐ Yes ☐ No Clotting: ☐ Yes ☐ No

Has your period ever skipped? _____ For how long? _____ Last Menstrual Period: _____

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long? _____

Do you use contraception? ☐ Yes ☐ No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility

☐ Painful Periods ☐ Heavy Periods ☐ PMS

Last Mammogram: _____ Breast Biopsy/Date: _____

Last PAP Test: _____ ☐ Normal ☐ Abnormal

Last Bone Density: _____ Results: ☐ High ☐ Low ☐ Within Normal Range

Are you in Menopause? ☐ Yes ☐ No Age at Menopause: _____

☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems ☐ Vaginal Dryness ☐ Decreased Libido

☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain ☐ Loss of Control of Urine ☐ Palpitations

☐ Use of hormone replacement therapy How long? _____

MEN'S HISTORY *(for men only)*

Have you had a PSA done? ☐ Yes ☐ No PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ > 10

☐ Prostate Enlargement ☐ Prostate Infection ☐ Change in Libido ☐ Impotence

☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection

☐ Nocturia (urination at night) How many times at night? _____

☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

Initials _____

MEDICATIONS

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

PREVIOUS MEDICATIONS *(Last 10 years)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No

Describe: _____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No

Have you had prolonged use of Tylenol? ☐ Yes ☐ No

Have you had prolonged or regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No

Frequent antibiotics ☐ Yes ☐ No

Long term antibiotics ☐ Yes ☐ No

Use of steroids (prednisone, nasal allergy inhalers) in the past ☐ Yes ☐ No

Use of oral contraceptives ☐ Yes ☐ No

Initials _____

MEDICAL HISTORY

☑ = *Past Condition* ☑ = *Ongoing Condition*

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

GASTROINTESTINAL

- ☐ ☐ Irritable Bowel Syndrome_____
- ☐ ☐ Inflammatory Bowel Disease_____
- ☐ ☐ Crohn's_____
- ☐ ☐ Ulcerative Colitis_____
- ☐ ☐ Gastritis or Peptic Ulcer Disease_____
- ☐ ☐ GERD (reflux)_____
- ☐ ☐ Celiac Disease_____
- ☐ ☐ Other_____

CARDIOVASCULAR

- ☐ ☐ Heart Attack_____
- ☐ ☐ Other Heart Disease_____
- ☐ ☐ Stroke_____
- ☐ ☐ Elevated Cholesterol_____
- ☐ ☐ Arrhythmia (irregular heart rate)_____
- ☐ ☐ Hypertension (high blood pressure)_____
- ☐ ☐ Rheumatic Fever_____
- ☐ ☐ Mitral Valve Prolapse_____
- ☐ ☐ Other_____

METABOLIC/ENDOCRINE

- ☐ ☐ Type 1 Diabetes_____
- ☐ ☐ Type 2 Diabetes_____
- ☐ ☐ Hypoglycemia_____
- ☐ ☐ Metabolic Syndrome_____
  (Insulin Resistance or Pre-Diabetes)
- ☐ ☐ Hypothyroidism (low thyroid)_____
- ☐ ☐ Hyperthyroidism (overactive thyroid)_____
- ☐ ☐ Endocrine Problems_____
- ☐ ☐ Polycystic Ovarian Syndrome (PCOS)_____
- ☐ ☐ Infertility_____
- ☐ ☐ Weight Gain_____
- ☐ ☐ Weight Loss_____
- ☐ ☐ Frequent Weight Fluctuations_____
- ☐ ☐ Bulimia_____
- ☐ ☐ Anorexia_____
- ☐ ☐ Binge Eating Disorder_____
- ☐ ☐ Night Eating Syndrome_____
- ☐ ☐ Eating Disorder (non-specific)_____
- ☐ ☐ Other_____

CANCER

- ☐ ☐ Lung Cancer_____
- ☐ ☐ Breast Cancer_____
- ☐ ☐ Colon Cancer_____
- ☐ ☐ Ovarian Cancer_____
- ☐ ☐ Prostate Cancer_____
- ☐ ☐ Skin Cancer_____
- ☐ ☐ Other_____

GENITAL AND URINARY SYSTEM

- ☐ ☐ Kidney Stones_____
- ☐ ☐ Gout_____
- ☐ ☐ Interstitial Cystitis_____
- ☐ ☐ Frequent Urinary Tract Infections_____
- ☐ ☐ Frequent Yeast Infections_____
- ☐ ☐ Erectile Dysfunction_____
  Or Sexual Dysfunction
- ☐ ☐ Other_____

MUSCULOSKELETAL/PAIN

- ☐ ☐ Osteoarthritis_____
- ☐ ☐ Fibromyalgia_____
- ☐ ☐ Chronic Pain_____
- ☐ ☐ Other_____

INFLAMMATORY/AUTOIMMUNE

- ☐ ☐ Chronic Fatigue Syndrome_____
- ☐ ☐ Autoimmune Disease_____
- ☐ ☐ Rheumatoid Arthritis_____
- ☐ ☐ Lupus SLE_____
- ☐ ☐ Immune Deficiency Disease_____
- ☐ ☐ Herpes-Genital_____
- ☐ ☐ Severe Infectious Disease_____
- ☐ ☐ Poor Immune Function_____
  (frequent infections)
- ☐ ☐ Food Allergies_____
- ☐ ☐ Environmental Allergies_____
- ☐ ☐ Multiple Chemical Sensitivities_____
- ☐ ☐ Latex Allergy_____
- ☐ ☐ Other_____

RESPIRATORY DISEASES

- ☐ ☐ Asthma_____
- ☐ ☐ Chronic Sinusitis_____
- ☐ ☐ Bronchitis_____
- ☐ ☐ Emphysema_____
- ☐ ☐ Pneumonia_____
- ☐ ☐ Tuberculosis_____
- ☐ ☐ Sleep Apnea_____
- ☐ ☐ Other_____

SKIN DISEASES

- ☐ ☐ Eczema_____
- ☐ ☐ Psoriasis_____
- ☐ ☐ Acne_____
- ☐ ☐ Melanoma_____
- ☐ ☐ Skin Cancer_____
- ☐ ☐ Other_____

Initials _____

MEDICAL HISTORY (continued)

☑ = *Past Condition* ☑ = *Ongoing Condition*

NEUROLOGIC/MOOD

- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Bipolar Disorder
- ☐ ☐ Schizophrenia
- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ ADD/ADHD
- ☐ ☐ Autism
- ☐ ☐ Mild Cognitive Impairment
- ☐ ☐ Memory Problems
- ☐ ☐ Parkinson's Disease
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ ALS
- ☐ ☐ Seizures
- ☐ ☐ Other Neurological Problems

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam
- ☐ Bone Density
- ☐ Colonoscopy
- ☐ Cardiac Stress Test
- ☐ EBT Heart Scan
- ☐ EKG
- ☐ Hemoccult Test-stool test for blood
- ☐ MRI
- ☐ CT Scan
- ☐ Upper Endoscopy
- ☐ Upper GI Series
- ☐ Ultrasound

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy
- ☐ Hysterectomy +/- Ovaries
- ☐ Gall Bladder
- ☐ Hernia
- ☐ Tonsillectomy
- ☐ Dental Surgery
- ☐ Joint Replacement – Knee/Hip
- ☐ Heart Surgery – Bypass Valve
- ☐ Angioplasty or Stent
- ☐ Pacemaker
- ☐ Other
- ☐ None

INJURIES

Check box if yes

- ☐ Back Injury
- ☐ Head Injury
- ☐ Neck Injury
- ☐ Broken Bones
- ☐ Other

BLOOD TYPE: ☐ A ☐ B ☐ AB ☐ O ☐ Rh+ ☐ unknown

HOSPITALIZATIONS ☐ **None**

Date	Reason

COMMENTS

Initials _____

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunt	Uncle	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson’s												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

Initials _____

SOCIAL HISTORY

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ☐ Yes ☐ No

Are you happy? ☐ Yes ☐ No

Do you feel your life has meaning and purpose? ☐ Yes ☐ No

Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No

Do you like the work you do? ☐ Yes ☐ No

Have you ever experienced major losses in your life? ☐ Yes ☐ No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? ☐ Yes ☐ No

Would you describe your experience as a child in your family as happy and secure? ☐ Yes ☐ No

STRESS/COPING

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No Describe: _____

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

Daily Stressors: Rate on scale of 1-10

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? ☐ Yes ☐ No How often? _____

Check all that apply: ☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? ☐ Yes ☐ No

SLEEP/REST

Average number of hours you sleep per night: ☐ > 10 ☐ 8-10 ☐ 6-8 ☐ < 6

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No Explain: _____

ROLES/RELATIONSHIP

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Long term partnership ☐ Widow

List Children: Child's Full Name	Age	Gender

Who is Living in Household? Number: _____ Names: _____

Their Employment/Occupations: _____

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

Are you satisfied with your sex life? ☐ Yes ☐ No

Initials _____

SYMPTOM REVIEW

Please check all current symptoms occurring or present in the past 6 months

CONSTITUTIONAL
- ☐ Cold Hands and Feet
- ☐ Cold Intolerance
- ☐ Low Body Temperature
- ☐ Daytime Sleepiness
- ☐ Difficulty Falling Asleep
- ☐ Early Awakening
- ☐ Fatigue
- ☐ Fever
- ☐ Flushing
- ☐ Heat Intolerance
- ☐ Night Waking
- ☐ Nightmares
- ☐ No Dream Recall

HEAD
- ☐ Headache
- ☐ Migraine
- ☐ Head Trauma
- ☐ Head Pain

EYES
- ☐ Conjunctivitis
- ☐ Lid Margin Redness
- ☐ Eye Crusting
- ☐ Eye Pain
- ☐ Vision Problems (other than glasses)
- ☐ Macular Degeneration
- ☐ Vitreous Detachment
- ☐ Retinal Detachment

EARS
- ☐ Ear Fullness
- ☐ Ear Pain
- ☐ Ear Ringing/Buzzing
- ☐ Hearing Loss
- ☐ Hearing Problems
- ☐ Sensitivity to Loud Noise

NOSE
- ☐ Distorted Sense of Smell
- ☐ Bad Odor in Nose
- ☐ Nasal Stuffiness
- ☐ Nose Bleeds
- ☐ Post Nasal Drip
- ☐ Sinus Fullness
- ☐ Sinus Infection
- ☐ Snoring
- ☐ Winter Stuffiness

MOUTH
- ☐ Distorted Taste
- ☐ Sore Mouth
- ☐ Sore Tongue
- ☐ Tooth Pain
- ☐ Periodontal Disease

THROAT
- ☐ Hoarseness
- ☐ Sore Throat
- ☐ Tonsillitis
- ☐ Voice Changes

NECK
- ☐ Swelling
- ☐ Suppurative Lesions
- ☐ Enlargement of the Lymph Nodes
- ☐ Goiter
- ☐ Stiffness
- ☐ Limitation of Motion

CARDIOVASCULAR
- ☐ Denies Angina/Chest Pain
- ☐ Breathlessness
- ☐ Heart Murmur
- ☐ Irregular Pulse
- ☐ Palpitations
- ☐ Phlebitis
- ☐ Swollen Ankles/Feet
- ☐ Varicose Veins

RESPIRATORY
- ☐ Cough-Dry
- ☐ Cough-Productive
- ☐ Shortness of Breath
- ☐ Hay Fever
- ☐ Snoring
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Anal Spasms
- ☐ Bad Teeth
- ☐ Bleeding Gums
- ☐ Bloating Lower Abdomen
- ☐ Bloating of Whole Abdomen
- ☐ Bloating After Meals
- ☐ Blood in Stools
- ☐ Burping
- ☐ Canker Sores
- ☐ Cold Sores
- ☐ Constipation
- ☐ Cracking at Corner of Lips
- ☐ Abdominal Cramps
- ☐ Dentures w/ Poor Chewing
- ☐ Diarrhea
- ☐ Alternating Diarrhea and Constipation
- ☐ Difficulty Swallowing
- ☐ Dry Mouth
- ☐ Excess Flatulence/Gas
- ☐ Fissures
- ☐ Food “Repeat” (Reflux)
- ☐ Gas
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Upper Abdominal Pain
- ☐ Vomiting
- ☐ Liver Disease/Jaundice (Yellow Eyes or Skin)
- ☐ Abnormal Liver Function Tests
- ☐ Lower Abdominal Pain
- ☐ Mucus in Stools
- ☐ Strong Stool Odor
- ☐ Undigested Food in Stools
- ☐ Intolerance to Lactose
- ☐ Intolerance to Dairy Products
- ☐ Intolerance to Wheat
- ☐ Intolerance to Gluten (Wheat, Rye, Barley)
- ☐ Intolerance To Corn
- ☐ Intolerance to Eggs
- ☐ Intolerance to Fatty Foods
- ☐ Intolerance to Yeast

GENITOURINARY
- ☐ Bed Wetting
- ☐ Urinary Hesitancy (trouble getting started)
- ☐ Infection
- ☐ Kidney Disease
- ☐ Leaking/Incontinence
- ☐ Pain/Burning
- ☐ Prostate Infection
- ☐ Urinary Urgency
- ☐ Discharge from Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Lumps in Testicles
- ☐ Poor Libido (Sex Drive)

Initials _____

SYMPTOM REVIEW (continued)

MUSCULOSKELETAL
- ☐ 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

SKIN
- ☐ 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
- ☐ Ears Get Red
- ☐ Easy Bruising
- ☐ Lack of Sweating
- ☐ Eczema
- ☐ Hives
- ☐ Jock Itch
- ☐ Lackluster Skin
- ☐ Moles w/Color/Size Change
- ☐ Oily Skin
- ☐ Pale Skin
- ☐ Patchy Dullness
- ☐ Rash
- ☐ Red Face
- ☐ Sensitivity to Bites
- ☐ Sensitivity to Poison Ivy/Oak
- ☐ Shingles
- ☐ Skin Darkening
- ☐ Strong Body Odor
- ☐ Hair Loss
- ☐ Vitiligo
- ☐ Itching of Skin in General
- ☐ Itching of Anus
- ☐ Itching of Eyes
- ☐ Itching of Specific Areas of Body
- ☐ Dryness of Eyes
- ☐ Dryness of Feet
- ☐ Skin Cracking
- ☐ Skin Peeling
- ☐ Hair Loss
- ☐ Dandruff

NEUROLOGICAL
- ☐ Syncope
- ☐ Dizziness
- ☐ Black-out
- ☐ Lightheadedness
- ☐ Numbness
- ☐ Seizures
- ☐ Tingling
- ☐ Tremor
- ☐ Visual Hallucinations
- ☐ Difficulty with Balance
- ☐ Difficulty with Thinking
- ☐ Difficulty with Judgement
- ☐ Difficulty with Speech
- ☐ Difficulty with Memory
- ☐ Difficulty with Concentration

PSYCHOLOGICAL
- ☐ Agoraphobia
- ☐ Anxiety
- ☐ Auditory Hallucinations
- ☐ Black-out
- ☐ Depression
- ☐ Fearfulness
- ☐ Irritability
- ☐ Panic Attacks
- ☐ Paranoia
- ☐ Suicidal Thoughts
- ☐ Sleep Disturbances
- ☐ Grandiose Ideas
- ☐ Alcohol or Drug Dependence
- ☐ Other Phobias

ENDOCRINE
- ☐ Binge Eating
- ☐ Bulimia
- ☐ Can't Gain Weight
- ☐ Can't Lose Weight
- ☐ Can't Maintain Healthy Weight
- ☐ Frequent Dieting
- ☐ Poor Appetite
- ☐ Changes in Hair Distribution
- ☐ Changes in Skin Pigmentation
- ☐ Goiter
- ☐ Intolerance to Heat or Cold
- ☐ Tremor
- ☐ Increased Thirst
- ☐ Salt Cravings
- ☐ Carbohydrate Craving (breads, pasta)
- ☐ Sweet Cravings (candy, cookies, cakes)
- ☐ Chocolate Cravings
- ☐ Caffeine Dependency

FEMALE REPRODUCTIVE
- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Libido (Sex Drive)
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain with Sex
- ☐ Premenstrual Bloating
- ☐ Premenstrual Breast Tenderness
- ☐ Premenstrual Carbohydrate Cravings
- ☐ Premenstrual Chocolate Cravings
- ☐ Premenstrual Constipation
- ☐ Premenstrual Decreased Sleep
- ☐ Premenstrual Diarrhea
- ☐ Premenstrual Fatigue
- ☐ Premenstrual Increased Sleep
- ☐ Premenstrual Irritability
- ☐ Menstrual Cramps
- ☐ Heavy Periods
- ☐ Irregular Periods
- ☐ No Periods
- ☐ Scanty Periods
- ☐ Spotting Between

Initials _____