

PATIENT SYMPTOM SURVEY

DATE _____

PATIENT'S NAME _____ AGE _____

WEIGHT _____ HEIGHT _____ BLOOD PRESSURE _____ PULSE _____ O2 _____

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time...

Primary Complaints

- | | | |
|--|---|--|
| 766 <input type="checkbox"/> Abdominal Pain R10.9 | 098 <input type="checkbox"/> Abdominal Gas/Bloating R14.0 | 002 <input type="checkbox"/> Acne L70.8 |
| 005 <input type="checkbox"/> ADD/ADHD F90.1/F90.9 | 006 <input type="checkbox"/> Allergies (unspecified) J30.9 | 007 <input type="checkbox"/> Allergic Rhinitis from food J30.5 |
| 144 <input type="checkbox"/> ALS (Lou Gehrig's Disease) G12.21 | 009 <input type="checkbox"/> Alzheimer's G30.9 | 768 <input type="checkbox"/> Amenorrhea M91.2 |
| 012 <input type="checkbox"/> Anemia D64.9 | 027 <input type="checkbox"/> Anxiety Disorder F41.9 | 028 <input type="checkbox"/> Autism F84.0 |
| 013 <input type="checkbox"/> Arthritic Disorder M12.9 | 015 <input type="checkbox"/> Asthma J45.909 | 765 <input type="checkbox"/> Bladder Disorder N32.9 |
| 181 <input type="checkbox"/> Brain Aneurysm I61.9 | 025 <input type="checkbox"/> Brain Tumor, malignant C71.9 | 018 <input type="checkbox"/> Breast Cancer (female) C50.919 |
| 094 <input type="checkbox"/> Breast Cancer (male) C50.929 | 017 <input type="checkbox"/> Cancer | 080 <input type="checkbox"/> Canker Sores K12.0 |
| 053 <input type="checkbox"/> Cataracts H26.9 | 763 <input type="checkbox"/> Cervical Cancer C53.9 | 035 <input type="checkbox"/> Chronic Fatigue R53.82 |
| 036 <input type="checkbox"/> Circulatory Disorder I99.9 | 021 <input type="checkbox"/> Colon/Rectal Cancer C18.9 | 043 <input type="checkbox"/> Constipation K59.00 |
| 088 <input type="checkbox"/> Crohn's disease K50.90 | 092 <input type="checkbox"/> Currently Pregnant Z33.1 | 046 <input type="checkbox"/> Depression F32.9 |
| 091 <input type="checkbox"/> Desires Nutritional and Metabolic Analysis | 047 <input type="checkbox"/> Diabetes Mellitus E11.9 | 049 <input type="checkbox"/> Dizziness/Balance problems R42 |
| 050 <input type="checkbox"/> Ear Infection H65.90 | 034 <input type="checkbox"/> Eczema L25.9 | 033 <input type="checkbox"/> Edema R60.9 |
| 016 <input type="checkbox"/> Emphysema J43.9 | 051 <input type="checkbox"/> Epstein Barr B27.90 | 052 <input type="checkbox"/> Eye Problems H57.13 |
| 056 <input type="checkbox"/> Fever R50.9 | 057 <input type="checkbox"/> Fibromyalgia M79.7 | 058 <input type="checkbox"/> Gallbladder Disorder K82.9 |
| 090 <input type="checkbox"/> General Good Health | 086 <input type="checkbox"/> GERD K21.9 | 054 <input type="checkbox"/> Glaucoma H40.9 |
| 171 <input type="checkbox"/> Goiter E04.9 | 059 <input type="checkbox"/> Gout M10.9 | 060 <input type="checkbox"/> Headaches R51 |
| 061 <input type="checkbox"/> Hearing Loss H91.90 | 037 <input type="checkbox"/> Heart Disease I51.9 | 179 <input type="checkbox"/> Hemochromatosis E83.119 |
| 065 <input type="checkbox"/> Hepatitis K71.6 | 066 <input type="checkbox"/> Hepatitis B B16.9 | 067 <input type="checkbox"/> Hepatitis C B17.10 |
| 087 <input type="checkbox"/> HIV Infection B20 | 076 <input type="checkbox"/> Hot flashes N95.1 | 038 <input type="checkbox"/> Hypercholesterolemia (High Cholesterol) E78.0 |
| 029 <input type="checkbox"/> Hyperglycemia (high blood sugar) R73.09 | 720 <input type="checkbox"/> Hypertension (High Blood Pressure) I10 | 069 <input type="checkbox"/> Hyperthyroid E05.90 |
| 770 <input type="checkbox"/> Hypocholesterolemia (Low Cholesterol) E78.6 | 048 <input type="checkbox"/> Hypoglycemia (low blood sugar) E16.2 | 721 <input type="checkbox"/> Hypotension (Low Blood Pressure) I95.9 |
| 070 <input type="checkbox"/> Hypothyroid E03.9 | 044 <input type="checkbox"/> Indigestion K30 | 072 <input type="checkbox"/> Infertility, Female N97.9 |
| 062 <input type="checkbox"/> Infertility, male N46.9 | 078 <input type="checkbox"/> Insomnia G47.00 | 073 <input type="checkbox"/> Interstitial Cystitis N30.11 |
| 074 <input type="checkbox"/> Irregular Menstrual Cycle N92.6 | 089 <input type="checkbox"/> Irritable Bowel Syndrome K58.9 | 068 <input type="checkbox"/> Kidney Disorder N28.9 |
| 023 <input type="checkbox"/> Leukemia w/o remission C95.90 | 095 <input type="checkbox"/> Leukemia w/ remission C95.91 | 064 <input type="checkbox"/> Liver Disease K76.9 |
| 040 <input type="checkbox"/> Low blood pressure I95.9 | 020 <input type="checkbox"/> Lung Cancer C34.90 | 071 <input type="checkbox"/> Lupus, systemic M32.10 |
| 142 <input type="checkbox"/> Lupus, non-systemic L93.0 | 024 <input type="checkbox"/> Lymphoma, malignant C85.89 | 055 <input type="checkbox"/> Macular Degeneration H35.30 |
| 722 <input type="checkbox"/> Malaise | 075 <input type="checkbox"/> Menopausal Symptoms N95.1 | 723 <input type="checkbox"/> Menorrhagia |
| 077 <input type="checkbox"/> Mental Disorder F99 | 140 <input type="checkbox"/> Migraines G43.909 | 724 <input type="checkbox"/> Motion Sickness |
| 079 <input type="checkbox"/> Mouth/Throat/Tongue | 143 <input type="checkbox"/> Multiple Sclerosis G35 | 725 <input type="checkbox"/> Myalgia |
| 726 <input type="checkbox"/> Myopia | 727 <input type="checkbox"/> Nasal Polyp | 728 <input type="checkbox"/> Nephritis |
| 729 <input type="checkbox"/> Nephrolithiasis (Kidney Stones) | 764 <input type="checkbox"/> Nosebleed | 042 <input type="checkbox"/> Numbness/Paresthesia R20.9 |
| 085 <input type="checkbox"/> Obesity E66.9 | 730 <input type="checkbox"/> Orgasm, poor/infrequent | 731 <input type="checkbox"/> Osteoarthritis |
| 014 <input type="checkbox"/> Osteoporosis M81.0 | 026 <input type="checkbox"/> Other Cancers | 081 <input type="checkbox"/> Overweight E66.3 |
| 732 <input type="checkbox"/> Pain in Limbs | 733 <input type="checkbox"/> Painful Urination | 011 <input type="checkbox"/> Parkinson's Disease G20 |
| 145 <input type="checkbox"/> Polymyalgia Rheumatica M35.3 | | |

- | | | |
|--|---|--|
| 010 <input type="checkbox"/> Poor Concentration/Memory F07.8 | 771 <input type="checkbox"/> Post stroke/brain aneurysm | 613 <input type="checkbox"/> Premenstrual Syndrome |
| 734 <input type="checkbox"/> Presbyopia | 019 <input type="checkbox"/> Prostate Cancer C61 | 735 <input type="checkbox"/> Prostate Cancer - screening |
| 063 <input type="checkbox"/> Prostate Disorder N42.9 | 003 <input type="checkbox"/> Psoriasis L40.8 | 178 <input type="checkbox"/> Raynaud's syndrome I73.00 |
| 736 <input type="checkbox"/> Rheumatism | 141 <input type="checkbox"/> Rheumatoid Arthritis M06.9 | 737 <input type="checkbox"/> Salivary Secretions |
| 146 <input type="checkbox"/> Scleroderma M34.9 | 738 <input type="checkbox"/> Scoliosis | 083 <input type="checkbox"/> Sexual Disorder F66 |
| 739 <input type="checkbox"/> Shortness of Breath | 093 <input type="checkbox"/> Shingles B02.9 | 008 <input type="checkbox"/> Sinusitis J01.90 |
| 022 <input type="checkbox"/> Skin Cancer C44.90 | 001 <input type="checkbox"/> Skin Disorder L25.9 | 94 <input type="checkbox"/> Skin Rash |
| 096 <input type="checkbox"/> Sneezing | 740 <input type="checkbox"/> Sore Throat | 084 <input type="checkbox"/> Spinal Problems M53.9 |
| 463 <input type="checkbox"/> Stammering/Stuttering | 741 <input type="checkbox"/> Stress Incontinence, female | 742 <input type="checkbox"/> Stress Incontinence, male |
| 097 <input type="checkbox"/> Swollen Joints | 743 <input type="checkbox"/> Syncope | 041 <input type="checkbox"/> Tachycardia (High Heart Rate) R00.0 |
| 744 <input type="checkbox"/> Tender Breasts | 180 <input type="checkbox"/> Thalassemia D56.8 | 745 <input type="checkbox"/> Thoracicalgia |
| 746 <input type="checkbox"/> Toothache | 747 <input type="checkbox"/> Tympanic Membrane (Ear Ache) | 030 <input type="checkbox"/> Type 1 Diabetes E10.9 |
| 031 <input type="checkbox"/> Type 2 Diabetes E11.65 | 045 <input type="checkbox"/> Ulcerative Colitis K51.90 | 082 <input type="checkbox"/> Underweight R63.6 |
| 748 <input type="checkbox"/> Urethra Discharge | 749 <input type="checkbox"/> Urinary Frequency | 004 <input type="checkbox"/> Urticaria (Hives) L50.9 |
| 750 <input type="checkbox"/> Vaginal Discharge | 751 <input type="checkbox"/> Vaginal Yeast Infection | 767 <input type="checkbox"/> Varicosities |
| 752 <input type="checkbox"/> Vertigo | 753 <input type="checkbox"/> Viral Warts | 099 <input type="checkbox"/> Wheezing |

If necessary, please state your most significant concern...

General Health

- | | | |
|--|--|---|
| 226 <input type="checkbox"/> Breast Cancer - Screening | 138 <input type="checkbox"/> Anti Rejection Drugs | 108 <input type="checkbox"/> Balance Problems |
| 100 <input type="checkbox"/> Base of fingernails are pink | 101 <input type="checkbox"/> Base of fingernails are purple | 107 <input type="checkbox"/> Blacks out easily |
| 111 <input type="checkbox"/> Brittle hair | 219 <input type="checkbox"/> Breast Cancer - History | 117 <input type="checkbox"/> Currently on Chemotherapy |
| 118 <input type="checkbox"/> Currently on Radiation treatments | 109 <input type="checkbox"/> Difficulty walking | 115 <input type="checkbox"/> Drinks alcoholic beverage(s) every day |
| 116 <input type="checkbox"/> Drinks less than 8 glasses of water per day | 112 <input type="checkbox"/> Dry hair | 755 <input type="checkbox"/> Energy level is better than it was 5 years ago |
| 756 <input type="checkbox"/> Energy level is the same as it was 5 years ago | 125 <input type="checkbox"/> Energy level is worse than it was 5 years ago | 102 <input type="checkbox"/> Fingernails have ridges or white spots |
| 103 <input type="checkbox"/> Fingernails are soft | 104 <input type="checkbox"/> Fingernails are splitting | 105 <input type="checkbox"/> Fingernails peel |
| 121 <input type="checkbox"/> Gained over 20 lbs within the last 12 months | 114 <input type="checkbox"/> Hair loss | 119 <input type="checkbox"/> Has had Chemotherapy in the past |
| 758 <input type="checkbox"/> Has had Chemotherapy within the last 3 months | 120 <input type="checkbox"/> Has had Radiation treatments in the past | 132 <input type="checkbox"/> Had a major accident or injury |
| 130 <input type="checkbox"/> Had Blood Transfusion in the Past | 131 <input type="checkbox"/> Had Transplant in the Past | 110 <input type="checkbox"/> Has tattoos |
| 769 <input type="checkbox"/> Is overweight | 754 <input type="checkbox"/> Is underweight | 124 <input type="checkbox"/> Lost over 20 lbs within the last 4 months |
| 106 <input type="checkbox"/> Pale fingernail beds | 757 <input type="checkbox"/> Pink fingernail beds | 126 <input type="checkbox"/> Rarely exercises |
| 129 <input type="checkbox"/> Sensitive to chemicals, paint, exhaust fumes, cologne | 127 <input type="checkbox"/> Sleeps less than 6 hours per night | 122 <input type="checkbox"/> Somewhat Overweight |
| 123 <input type="checkbox"/> Somewhat Underweight | 113 <input type="checkbox"/> Thin hair | 128 <input type="checkbox"/> Unable to recall dreams the next day |
| 187 <input type="checkbox"/> Family history of Alcoholism | 184 <input type="checkbox"/> Family history of Cancer | 188 <input type="checkbox"/> Family history of Depression |
| 186 <input type="checkbox"/> Family history of Diabetes | 185 <input type="checkbox"/> Family history of Heart Disease | 189 <input type="checkbox"/> Family history of Obesity |
| 149 <input type="checkbox"/> Had Chemotherapy in the last year | 176 <input type="checkbox"/> Had childhood vaccinations | 148 <input type="checkbox"/> Had Radiation therapy in the last year |
| 175 <input type="checkbox"/> Has been out of the country recently | 177 <input type="checkbox"/> Has been vaccinated in the last 12 months | 147 <input type="checkbox"/> Has had a flu shot in the last year |

183 Has had a Hepatitis vaccine within the last 2 years

139 Toxic Chemical Exposure

182 Has had a pneumonia vaccine in the last year

137 Sleep Apnea

206 Dairy

209 Gluten

212 Ragweed

215 Sulfa Drugs

218 Other allergies

207 Eggs

210 Mold

213 Shellfish

216 Tree Nuts

208 Garlic

211 Peanut

214 Soy

217 Wheat

Allergies

Behavior Patterns

150 Afraid to eat anywhere except home

152 Cries often

155 Difficulty staying asleep

158 Frequently becomes scared for no reason

161 Often annoyed by people

166 Scared to be alone

168 Under considerable emotional stress

151 Always needs someone to advise

153 Difficulty concentrating

156 Easily angered

159 Frequently miserable or blue

165 Poor memory

163 Sometimes wishes to be dead or away from it all

169 Unhappy when others are happy

170 Brain Fog

154 Difficulty falling asleep

157 Feelings are easily hurt

160 Has to be on guard even with friends

162 Recurrent bad dreams

167 Strange people or places cause fear

164 Upset by criticism

Cardiovascular

197 At Times Low Blood Pressure

192 Experiences shortness of breath while sitting still

205 Heart palpitations

196 Leg cramps during daytime

201 Spells of rapid heart rate

203 Unusually slow heart rate (Bradycardia)

190 Cold feet

199 Frequent swollen ankles

039 High blood pressure

198 Pain in leg/hips when walking

194 Tendency of High Blood Pressure

204 Varicose veins

191 Cold hands

193 Heart skips beats

195 Leg cramps during bedtime

200 Pains in the heart or chest

202 Troubled with blood clots

Ears

220 Discharge from ears

223 Recurrent ear infections

221 Hard of hearing

224 Ringing or noises in the ears

222 Punctured ear drum

225 Tinnitus

Endocrine

245 Coarse hair

248 Excessive thirst

251 Gets lightheaded when standing quickly

253 Unusually jumpy or nervous

246 Coarse skin

249 Frequently feels cold

252 Heals slowly

254 Unusually tired most of the time

247 Diabetic

250 Frequently feels hot

255 Swollen Lymph glands

Eyes

320 Bloodshot eyes

332 Dry Eyes

325 Eyes water

330 Itchy eyes

329 Mild Macular Degeneration

321 Blurred Vision

323 Eye pain

327 Far sighted

328 Mild Cataracts

331 Near sighted

322 Cross eyes

324 Eyes feel gritty

759 Has or has had cataracts

326 Mild Glaucoma

Feet

- 350 Corns
- 352 Heel spurs
- 354 Plantar warts

- 351 Frequent foot cramps
- 353 Painful feet
- 355 Swelling in the feet and/or ankles

- 357 Fungal Infection
- 356 Plantar Fasciitis

Gastrointestinal

- 266 3 or less bowel movements per week
- 277 Abdominal gas
- 279 Bloating after eating
- 300 Diverticulitis
- 289 Eats when nervous
- 293 Feels shaky when hungry
- 276 Frequent vomiting
- 302 Greasy foods cause indigestion
- 272 Hemorrhoids (piles)
- 286 Indigestion within 1 hour after meals
- 273 Loose bowel movements
- 297 Reflux/Hiatal Hernia
- 271 Tends to constipation

- 265 4-5 bowel movements per week
- 278 Belching and burping after eating
- 270 Bloody Stools
- 301 Diverticulosis
- 290 Excessive hunger
- 274 Frequent diarrhea
- 294 Frequently drowsy after eating a meal
- 760 Has constipation
- 284 Immediate indigestion upon eating
- 299 Irritable Bowel
- 269 Pale or yellow colored stool
- 280 Severe abdominal pains
- 282 Uses digestive aids

- 267 6 or more bowel movements per week
- 268 Black tarry stools
- 287 Difficulty swallowing
- 288 Eating relieves fatigue
- 292 Experiences fainting spells when hungry
- 275 Frequent nausea
- 295 Gall bladder disease
- 296 Has had intestinal worms
- 285 Indigestion in 2 hours or more after meals
- 298 Liver disease
- 291 Poor appetite
- 281 Stomach ulcers
- 283 Uses laxatives

Lifestyle Habits

- 389 Anorexia R63.0
- 382 Currently smokes
- 372 Drinks caffeinated pop/soda
- 392 Drinks coffee
- 388 Drinks diet pop/soda
- 379 Drinks 1 or more pop/sodas per day
- 136 Eats no meat, no dairy
- 174 Had 4 alcoholic drinks in one day less than 3 months ago
- 172 Never had 4 alcoholic drinks in one day
- 384 Smoked for more than 5 years
- 134 Vegetarian
- 342 Home water is filtered
- 345 Home pipes are copper
- 348 Home renovations within the last year
- 361 Has worked around industrial solvents, chemicals or pesticides

- 390 Bulimia
- 370 Drinks alcohol
- 373 Drinks caffeinated tea
- 374 Drinks decaffeinated coffee
- 377 Drinks more than 3 cups of coffee per day
- 380 Drinks beverages from a can
- 135 Eats no red meat
- 173 Had 4 alcoholic drinks in one day more than 3 months ago
- 383 Quit smoking in the last 5 years
- 385 Smokes more than 1 pack per day
- 340 Home has well water
- 343 Home pipes are steel
- 346 Home pipes are PEX
- 349 Uses chlorine bleach or other heavy duty chemicals

- 391 Craves Sugars/starches
- 371 Drinks caffeinated coffee
- 375 Drinks Decaffeinate Pop/Soda
- 376 Drinks decaffeinated tea
- 378 Drinks more than 3 cups of tea per day
- 393 Drinks tea
- 387 Frequent use of Artificial Sweeteners
- 381 Has more than 5 alcoholic drinks per week
- 133 Regularly exercises
- 386 Takes vitamins
- 341 Home has city water
- 344 Home pipes are PVC
- 347 Home built prior to 1978
- 360 Has worked in plumbing, automotive or metallurgic industry

Mouth and Throat

- 418 Amalgam dental fillings

- 400 Bad breath

- 401 Bitter taste in the mouth in the morning

- 772 Dental Fillings (gold, composite etc.)
 406 Frequent canker sores
 409 Frequently has a sore tongue
 419 Have had root canals
 404 Sores or cracks in the corners of the mouth
 413 Tongue burns
 417 Toothaches

- 402 Dry mouth
 407 Frequent fever blisters
 405 Glands often swell
 420 Other dental fillings
 411 Swollen gums
 414 Tongue has grooves or fissures

- 403 Excessive saliva
 408 Frequent sore throats
 416 Gums bleed when brushing teeth
 410 Sore gums
 412 Swollen tongue
 415 Tongue is coated

Neuromuscular

- 440 Bites nails
 447 Frequently feels faint
 450 Has Osteoarthritis
 455 Leg pain at rest
 443 Muscle weakness
 461 Numbness/tingling in the body
 452 Rheumatoid Arthritis
 456 Spinal curvature
 444 Tremors/Shakes

- 445 Frequent headaches
 448 Has Epilepsy
 451 Has Rheumatism
 457 Low back pain
 458 Neck pain
 446 Often dizzy
 460 Shoulder/arm pain
 761 Stutters or stammers

- 441 Frequent muscle soreness
 449 Has Motion Sickness
 453 Joint stiffness in the morning
 442 Muscle spasms
 464 Nerve Pain
 459 Pain between the shoulders
 462 Sleep walks
 454 Swollen joints

Respiratory

- 485 Catches severe colds
 488 Constant runny nose
 491 Frequent colds
 494 Frequent stuffy nose
 496 Nasal polyps
 500 Spits up blood

- 486 Chronic chest condition
 489 COPD
 492 Frequent nose bleeds
 503 Has asthma
 498 Post nasal drip
 501 Spits up phlegm

- 487 Chronic cough
 490 Difficulty breathing
 493 Frequent sinus infections
 495 Hay fever
 499 Sneezing spells
 502 Wheezes

Women Only

- 497 Night sweats
 616 Acne worse at menstruation
 647 Breast Fibroids
 648 Currently breastfeeding
 643 D & C
 617 Excessive menstrual flow
 621 Has taken birth control medication for more than one year
 637 Herpes infection
 609 Mastitis
 646 Ovarian Fibroids
 629 Poor or infrequent orgasm
 638 Sexual diseases
 644 Tubal Pregnancy
 762 Vagina dryness

- 612 Abnormal cycle >29 days and/or <26 days
 634 Bloody spotting discharge
 707 Breast Implants
 620 Currently taking birth control medication
 627 Diminished sexual desire
 636 External genital sores
 622 Has taken birth control medication within the last year
 632 Hysterectomy
 614 Menstrual cramps
 628 Painful intercourse
 619 Pre-menstrual depression
 625 Takes hormone replacement medication
 645 Uterine Fibroids
 635 Yeast infections

- 642 Abortion
 641 Breast Augmentation
 640 Breast Reduction
 611 Cycles are every 27-29 days
 639 Endometriosis
 623 Has had miscarriage
 610 Heavy hair growth on face or body
 630 Lumps in the breasts
 624 Mild to Moderate Hot Flashes
 615 Painful periods
 618 Retains fluid during periods
 631 Tender breasts
 633 Vaginal discharge

Skin

- 534 Dry Skin
 522 Frequent goose bumps

- 520 Bruises easily
 523 Has Acne

- 521 Excessive perspiration

- 528 Has moles which are changing in size and/or color
526 Itchy skin
530 Skin is rough, especially on the back of the arms
533 Troubled with boils

- 524 Has Psoriasis
527 Problems with Eczema
531 Skin is tender

- 525 Hives
529 Skin eruptions
532 Sores that heal slowly

Urinary

- 555 Urinates more than 2 times per night
558 Difficulty starting urination
560 Frequent urination
563 Loses bladder control

- 556 Bed wetting
564 Frequent bladder infections
562 Incontinence when sneezing or laughing
559 Painful urination

- 557 Blood in the urine
565 Frequent kidney infections
566 Kidney stones
561 Troubled by urgent urination

Men Only

- 585 Difficulty completing intercourse
588 Had a vasectomy
584 Inflammation of Testis
591 Painful genitals
593 Sores on external genitalia

- 586 Difficulty getting or keeping an erection
589 Had difficulty fathering children
596 Low sex drive
592 Prostate troubles

- 587 Discharge from the urethra
594 Herpes
590 Lumps in the testicles
595 Sexual Diseases

Surgeries

- 701 Appendix removed
716 Cataract Surgery
702 Gallbladder removed
704 Hysterectomy, complete
715 Radiated Thyroid
703 Thyroid removed

- 718 Bariatric/Weight loss surgery
709 Coronary Bypass
717 Hemorrhoid Surgery
705 Hysterectomy, partial
710 Spinal Surgery
700 Tonsils and/or Adenoids removed

- 708 Cancer surgery
711 Extremity Surgery
712 Hip Replacement
713 Knee Replacement
714 Spleen Removed (Splenectomy)
706 Tubal Ligation (fallopian tubes tied)

Medications

Please list all drugs you are currently taking on a daily basis.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

<u>VITAMIN</u>	<u>BRAND</u>	<u>DOSAGE</u>