

Name _____ Age _____ DOB _____ M F Date _____

MALE

past current

- | | | |
|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Testicular pain/mass |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital sores/discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital itching |
| <input type="checkbox"/> | <input type="checkbox"/> | Weak urine stream |
| <input type="checkbox"/> | <input type="checkbox"/> | Impotence |
| <input type="checkbox"/> | <input type="checkbox"/> | Nocturnal emission |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature ejaculation |
| <input type="checkbox"/> | <input type="checkbox"/> | Prostate disease |

INFECTION SCREENING

Positive negative

- | | | |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | TB |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV |
| <input type="checkbox"/> | <input type="checkbox"/> | Chlamydia |
| <input type="checkbox"/> | <input type="checkbox"/> | Gonorrhea |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital warts |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes oral/genital |

FEMALE

past current

- | | | |
|--------------------------|--------------------------|--------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Premenstrual syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful periods |
| <input type="checkbox"/> | <input type="checkbox"/> | Endometriosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast lumps |
| <input type="checkbox"/> | <input type="checkbox"/> | Breast tenderness |
| <input type="checkbox"/> | <input type="checkbox"/> | Nipple discharge |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent vaginal infect |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain/itching of genitals |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital sores/warts |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal discharge/odor |
| <input type="checkbox"/> | <input type="checkbox"/> | Vaginal dryness |
| <input type="checkbox"/> | <input type="checkbox"/> | Peri-menopausal |
| <input type="checkbox"/> | <input type="checkbox"/> | Menopausal symptom |
| <input type="checkbox"/> | <input type="checkbox"/> | PID - Pelvic
Inflammatory Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Trouble conceiving |

OTHER

ENDOCRINE & IMMUNE SYSTEM

past current

- | | | |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid imbalance |
| <input type="checkbox"/> | <input type="checkbox"/> | Heat or cold intolerance |
| <input type="checkbox"/> | <input type="checkbox"/> | Swelling of hands/feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic fatigue syn. |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus |

PSYCHOLOGICAL

past current

- | | | |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Anxiety |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Irritability |
| <input type="checkbox"/> | <input type="checkbox"/> | Easily stressed |
| <input type="checkbox"/> | <input type="checkbox"/> | Consider/attempt
Suicide |
| <input type="checkbox"/> | <input type="checkbox"/> | Receive counseling |
| <input type="checkbox"/> | <input type="checkbox"/> | Eating disorder |