PLEASE READ FIRST

Dear New Clients:

Thank you for demonstrating confidence in our clinic by your decision to make an appointment to see our doctor. We acknowledge and respect your commitment to pursue improvement in your state of health. In return, our team commits to doing our best in order to help you achieve your goals with respect to your health. It has been our experience that lasting improvements in ones health take place in the presence of both heightened focus and dedication. It is with this in mind that we ask our new clients to pay careful attention to the materials sent to them in this package. Read every question carefully and respond to the best of your ability. Thorough completion of the questionnaires and surveys not only improves the accuracy of your assessment but it also improves the efficiency of your communication with the doctor, thus reducing the need for extended consultation time. This subsequently saves you money.

Please read and complete the materials in the order you have received them in this package. Note that you will need to get started on the Diet and Activity Survey and the Axillary Temperature Test promptly, as both of these require time and careful attention. Remember, being conscious of what you eat, drink and do is vital to your health. We also need to know exactly how your system responds to your current lifestyle choices, so please complete the other forms carefully as well.

We suggest that you get started on them right away, as opposed to the night before your appointment for two reasons:

(1) Many of the questions require close observation of your bodily functions over several days in order to respond accurately.
(2) These forms should be returned to this office in advance of your appointment date in order for the doctor to have time to review them properly.

We ask that you return them in person or by courier at least 5 days in advance of your first appointment date. Please do not mail them as the mail system is not reliable and you do not want to have to re-do these forms. In those exceptional cases where the appointment is made one or two days prior to the consultation, certain concessions obviously apply. Whatever the circumstances, we ask that you make the appropriate effort to provide the information required. Many find the completion of these forms a valuable process in itself.

For those traveling long distances or who have restricted access to our office for whatever reason, be sure to make this clear to the front desk staff **PRIOR TO** your initial appointment so that they may schedule a multifunction, extended appointment time (two or three visits in one) when possible. In some cases there will also be certain laboratory assessments done at this time so be sure to read and follow the lab instructions exactly.

If you are feeling somewhat challenged after review of the assessment forms and the materials provided, simply reflect on the most satisfying and worthwhile endeavors that you have accomplished to date in your life and then ask yourself if there was any commitment involved. Of course there was and the rules are no different with respect to our health challenges. So focus on the rewards and remember how one can eat a whale, “one bite at a time”. (Vegetarians please forgive the metaphor!)

If you feel that we have overlooked anything, or that you would like further clarification, please feel free to call us!

We look forward to serving you,

Dr Shea and Staff

SANTA CRUZ CENTER

FOR HEALTH & WELL-BEING

Caring, innovative health solutions to enhance your life

ADULT MEDICAL QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Name: _________________ Middle Name: _______________ Last Name: ____________________

Address: ______________________________ City: _________________ State: _______ ZIP: _________

Home Phone: (________) ________-___________ Birth Date: _____/____/____ Age: _________
month day year

Work Phone: (________) ________-___________

Place of Birth: _____________________________
City or town & country if not US

Occupation: ______________________________

Referred by: ______________________________ Height: ___′ ____ ″ Weight: _______ Sex: _____

Today’s Date ______________________________

1. Please check appropriate box(es):

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European ☐ Other

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			

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d.			
e.			
f.			
g.			

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister
   ____
   ____
   ____

4. Do you have any pets or farm animals? Yes____ No____
   If yes, where do they live? 1. _____ indoors 2. _____ outdoors 3. _____ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes____ No____
   If so, when and where?
   ____
   ____

6. Have you or your family recently experienced any major life changes? Yes____ No____
   If yes, please comment:
   ____
   ____

7. Have you experienced any major losses in life? Yes____ No____
   If so, please comment:
   ____
   ____

8. How important is religion (or spirituality) for you and your family's life?
   a. _____ not at all important
   b. _____ somewhat important
   c. _____ extremely important

9. How much time have you lost from work or school in the past year?
   a. _____ 0-2 days
   b. _____ 3 –14 days
   c. _____ > 15 days

10. Previous jobs:
   ____
   ____
   ____

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11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

    Please do your best to answer the following questions:

    a. Did you feel safe growing up?
       ▫ Yes ▫ No
    b. Have you been involved in abusive relationships in your life?
       ▫ Yes ▫ No
    c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
       ▫ Yes ▫ No
    d. Do you currently feel safe in your home?
       ▫ Yes ▫ No
    e. Do you feel safe, respected and valued in your current relationship?
       ▫ Yes ▫ No
    f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
       ▫ Yes ▫ No
    g. Would you feel safer discussing any of these issues privately?
       ▫ Yes ▫ No

12. Past Medical and Surgical History:

	ILLNESSES	**WHEN**	**COMMENTS**
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn’s Disease or Ulcerative Colitis		
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Gallstones		
l.	Gout		
	ILLNESSES	**WHEN**	**COMMENTS**

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m.	Heart attack/Angina		
n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		
	INJURIES	**WHEN**	**COMMENTS**
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
	DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		

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aq. NMR/MRI		
ar. Sigmoidoscopy		
as. Upper GI Series		
at. Other (describe)		
OPERATIONS	**WHEN**	**COMMENTS**
au. Appendectomy		
av. Dental Surgery		
aw. Gall Bladder		
ax. Hernia		
ay. Hysterectomy		
az. Tonsillectomy		
ba. Other (describe)		
bb. Other (describe)		

13. Hospitalizations:

WHERE HOSPITALIZED	**WHEN**	**FOR WHAT REASON**
a.		
b.		
c.		
d.		
e.		

14. How often have you have taken antibiotics?

	< 5 times	**> 5 times**
Infancy/ Childhood		
Teen		
Adulthood		

15. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

	< 5 times	**> 5 times**
Infancy/ Childhood		
Teen		
Adulthood		

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16. What medications are you taking now? Include non-prescription drugs.

Medication Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Are you allergic to any medications? Yes____ No____

If yes, please list:

____

____
____

17. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

18. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				

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2. As a child did you eat a lot of sugar and/or candy?				

19. As a child, were there any foods that you had to avoid because they gave you symptoms?

Yes____ No____

If yes, please: name the food and symptom (Example: milk – gas and diarrhea)
____
____
____
____
____

20. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

	Usual Breakfast	√		**Usual Lunch**	√		**Usual Dinner**	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
	Usual Breakfast	√		**Usual Lunch**	√		**Usual Dinner**	√
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	

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u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

21. How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Diet sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	
l.	Sodas with caffeine	
m.	Sodas without caffeine	

22. Are you on a special diet? Yes____ No____

_____ ovo-lacto
_____ diabetic
_____ dairy restricted

_____ vegetarian
_____ vegan
_____ blood type diet

_____ other (describe):
____
____

23. Is there anything special about your diet that we should know? Yes____ No____
If yes, please explain:
____
_

24. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?

Yes____ No____

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b. If yes, are these symptoms associated with any particular food or supplement(s)? Yes____ No____

c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

____

____

25. Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____

26. Do you feel much **worse** when you eat a lot of :

_______high fat foods
_______high protein foods
_______high carbohydrate foods (breads, pastas, potatoes)
_______refined sugar (junk food)
_______fried foods
_______1 or 2 alcoholic drinks
_______other _____________________________

27. Do you feel much **better** when you eat a lot of :

_______high fat foods
_______high protein foods
_______high carbohydrate foods (breads, pastas, potatoes)
_______refined sugar (junk food)
_______fried foods
_______1 or 2 alcoholic drinks
_______other _____________________________

28. Does skipping a meal greatly affect your symptoms? Yes____ No____

29. Have you ever had a food that you craved or really "binged" on over a period of time?

Food craving may be an indicator that you may be allergic to that food. Yes____ No____

If yes, what food(s)? ____

____

30. Do you have an aversion to certain foods? Yes____ No____

If yes, what foods?

____

31. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			

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Diarrhea	
Thin, long or narrow	
Small and hard	
Loose but not watery	
Alternating between hard and loose/watery	

32. Intestinal gas: _______Daily _______Occasionally _______Excessive
Present with pain ______Foul smelling ______Little odor

33. a. Have you ever used alcohol? Yes____ No____
b. If yes, how often do you now drink alcohol?
___ No longer drinking alcohol
___ Average 1-3 drinks per week
___ Average 4-6 drinks per week
___ Average 7-10 drinks per week
___ Average >10 drinks per week
c. Have you ever had a problem with alcohol? Yes____ No____

If yes, please indicate time period (month/year): from ________ to ___________.

34. Have you ever used recreational drugs? Yes____ No____

35. Have you ever used tobacco? Yes____ No____
If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.
If yes, what type of nicotine have you used? _____Cigarette _____ Smokeless _____Cigar _____Pipe _____Patch/Gum

36. Are you exposed to second hand smoke regularly? Yes____ No____

37. Do you have mercury amalgam fillings? Yes____ No____

38. Do you have any artificial joints or implants? Yes____ No____

39. Do you feel worse at certain times of the year? Yes____ No____
If yes, when? _______spring _______fall _______summer _______winter

40. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes____ No____
If yes, which one(s)? ______lead _______cadmium _______arsenic _______mercury _______aluminum

41. Do odors affect you? Yes____ No____

42. How well have things been going for you?

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	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

43. Have you ever had psychotherapy or counseling? Yes____ No____
Currently? _____ Previously? _____ If previously, from ______ to _______.
What kind?
____
Comments:
____

44. Are you currently, or have you ever been, married? Yes____ No____
If so, when were you married? __________ Spouse's occupation
____
When were you separated? __________ Never _____
When were you divorced? __________ Never _____
When were you remarried? __________ Never _____ Spouse's occupation
____
Comments:
____

45. Hobbies and leisure activities:
____
____

46. Do you exercise regularly? Yes____ No____

If so, how many times a week?
1.______1x
2.______2x
3.______3x
4.______4x or more

When you exercise, how long is each session?
1.______ ≤15 min
2.______ 16-30 min
3.______ 31-45 min
4.______ > 45 min

What type of exercise is it?
_______jogging/walking
_______basketball
_______tennis
_______water sports

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_______home aerobics _______other ____

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47. FAMILY HISTORY: For each member of your family, follow the grey or white line across the page and check the boxes for:

1. Their present state of health, and
2. Any illnesses they have had.

(Note: Except for ***spouse****, Family refers to* ***blood*** *or* ***natural*** *relatives.)* **PRINT NAMES BELOW**	**Good Health**	**Poor Health**	**Deceased**	**Write in age and cause of death. Include accidents and suicides.**	**lcoholis**	**Allergies or Asthma**	**Alzheimer's or Dementia**	**Anemia**	**Blood Clotting Problems**	**Diabetes**	**Cancer or Tumor**	**Epilepsy**	**Genetic Disease**	**Heart Trouble**	**High Blood Pressure**	**Kidney or Bladder Dis.**	**Nervous Breakdown**	**Rheumatism or Arthritis**	**Stomach or Duodenal Ulcer**
Father																			
Mother:																			
Brothers/Sisters:																			
Spouse:																			
Child:																			
Child:																			
Child:																			
Child:																			
Paternal relatives (in each box, write in how many affected with condition):																			
Maternal relatives (in each box, write in how many affected with condition):																			

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48. Any other family history we should know about? Yes____ No____
If so, please comment:
____

49. What is the attitude of those close to you about your illness?
_______Supportive
_______Non-supportive

FOR WOMEN ONLY (questions 50-58):

50. Have you ever been pregnant? (If no, skip to question 53.) Yes____ No____

Number of miscarriages _____ Number of abortions _____ Number of preemies _____

Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

Did you develop toxemia (high blood pressure)? Yes____ No____

Have you had other problems with pregnancy? Yes____ No____

If so, please comment: ____

51. Age at first period _____ Date of last Pap Smear __________ Date of last Mammogram____________
Pap Smear: ___ Normal ___Abnormal
Mammogram: ___ Normal ___ Abnormal

52. Have you ever used birth control pills? Yes____ No____ If yes, when _________

53. Are you taking the pill now? Yes____ No____

54. Did taking the pill agree with you? Yes____ No____ Not applicable _____

55. Do you currently use contraception? Yes____ No____
If yes, what type of contraception do you use?
____

56. Are you in menopause? No _____ Yes _____ If yes, age at last period______
Do you take: Estrogen?___ Ogen?___ Estrace?___ Premarin?___ Other (specify)___________
Progesterone?___ Provera? ___ Other (specify) _______________

57. How long have you been on hormone replacement therapy (if applicable)? _________________

58. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes____ No____ Not applicable _____

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59. Please check if these symptoms occur presently **or** have occurred in the past 6 months.

GENERAL:	**Mild**	**Mod-erate**	**Severe**
Cold hands & feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES & EARS:			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL:	**Mild**	**Mod-erate**	**Severe**
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			
MOOD/NERVES:			
Agoraphobia			
Anxiety			

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Auditory hallucinations			
Black-out			
Depression			
Difficulty: Concentrating			
With balance			
With thinking			
With judgment			
With speech			
With memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			
Light-headedness			
MOOD/NERVES, Cont'd:	**Mild**	**Mod-erate**	**Severe**
Numbness			
Other Phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
EATING:			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			

Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			
DIGESTION:			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of: Lower abdomen			
Whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures w/poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			
DIGESTION, Cont'd:	**Mild**	**Mod-erate**	**Severe**
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			

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All milk products			
Intolerance to: Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
SKIN PROBLEMS:			
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			

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SKIN PROBLEMS, Cont'd:	Mild	Mod - erate	Sever e
Eczema			
Herpes - genital			
Hives			
Jock itch			
Lackluster skin			
Moles w color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/ oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING:			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

SKIN, DRYNESS OF:	Mild	Mod - erate	Sever e
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
LYMPH NODES:			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
NAILS:			

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Bitten			
Brittle			
Curve up			
Frayed			
Fungus - fingers			
Fungus - toes			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of: Finger nails			
Toenails			
White spots/lines			

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RESPIRATORY:	Mild	Mod - erate	Sever e
Bad breath			
Bad odor in nose			
Cough - dry			
Cough - productive			
Hay fever : Spring			
Summer			
Fall			
Change of season			
Hoarseness			
Nasal stuffiness			
Nose bleeds			
Post nasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

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URINARY:	Mild	Mod-erate	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
MALE REPRODUCTIVE:			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			
FEMALE REPRODUCTIVE:			
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			

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FEMALE REPRODUCTIVE, Cont'd:	**Mild**	**Mod-erate**	**Severe**
Premenstrual: Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

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