

Name: _____

Date: _____

Age: _____

The following is a list of symptoms or complaints you may or may not have. Please read each one and check all that apply to you currently, even if they may not have changed since your last visit.

- ____ Feel cold much of the time
- ____ Fingers or toes turn blue at times
- ____ "Hot Flashes" or sweating spells (at night or other times not related to exercise)
- ____ Dizziness or feeling like you're going to pass out
- ____ Dry Mouth
- ____ Frequent gum chewing
- ____ Unusually fast heart beat
- ____ Irregular heart beats (it feels like it skips a beat or feels like it "jumps" at times)
- ____ Chest Pain
- ____ Shortness of breath or trouble breathing
- ____ Difficulty thinking straight or remembering to do things
- ____ Trouble falling or staying asleep
- ____ Swollen feet or hands
- ____ Stomach aches
- ____ Noticeable blood when you have thrown up or gone to the bathroom
- ____ Notice something that looks like coffee grounds when you throw up
- ____ Cut yourself
- ____ Pain in one or more of your bones or joints (like your shin or feet)

- ____ I have thrown up at least once recently
- ____ I have taken laxatives recently
- ____ I have taken diet pills recently
- ____ I have taken water pills recently
- ____ I have been drinking alcohol enough to get drunk recently
- ____ I have taken other stuff that I would rather not talk about
- ____ I have thought about hurting or killing myself recently

My last menstrual cycle was _____.

I eat approximately _____ calories/day.
I do not know _____

I drink approximately _____ ounces of fluid/day (water, milk, soft drinks, etc).
I do not know _____

I use a lot of _____ on my foods. (fill in the blank)