Willow Wellness CLINIC

Name: _____

Date: _____

Y = A condition you have **now**
P = A condition you have had in the **past**

GENERAL
Weight_____
Height _____
Recent weight change ❑Y ❑P
Fatigue/Weakness ❑Y ❑P

SKIN
Rashes ❑Y ❑P
Eczema, hives ❑Y ❑P
Acne, boils ❑Y ❑P
Itching ❑Y ❑P
Colour change ❑Y ❑P
Lumps ❑Y ❑P
Night sweats ❑Y ❑P
Dryness/moistness ❑Y ❑P
Temperature changes ❑Y ❑P
Nail changes ❑Y ❑P
Changes in mole ❑Y ❑P
Skin cancer ❑Y ❑P

HEAD
Headache ❑Y ❑P
Head injury ❑Y ❑P
Dizziness ❑Y ❑P
Changes in hair Texture/quantity ❑Y ❑P

EYES
Impaired vision ❑Y ❑P
Eye pain ❑Y ❑P
Tearing/dryness ❑Y ❑P
Double vision ❑Y ❑P
Glaucoma ❑Y ❑P
Cataracts ❑Y ❑P
Blurring ❑Y ❑P
Itching ❑Y ❑P
Redness ❑Y ❑P
Discharge ❑Y ❑P
Blind spot ❑Y ❑P

EARS
Impaired hearing ❑Y ❑P
Earache ❑Y ❑P
Dizziness ❑Y ❑P
Discharge ❑Y ❑P
Infections ❑Y ❑P
Ringing ❑Y ❑P

NOSE/SINUSES
Frequent colds ❑Y ❑P
Nose bleeds ❑Y ❑P
Stuffiness ❑Y ❑P
Hay fever ❑Y ❑P
Sinus problems ❑Y ❑P
Post-nasal drip ❑Y ❑P

MOUTH/THROAT
Freq sore throat ❑Y ❑P
Sore tongue/mouth ❑Y ❑P
Gum problems ❑Y ❑P
Hoarseness ❑Y ❑P
Dental cavities ❑Y ❑P
Loss of taste ❑Y ❑P

NECK
Lumps ❑Y ❑P
Swollen glands ❑Y ❑P
Goitre ❑Y ❑P
Pain/stiffness ❑Y ❑P

RESPIRATORY
Cough ❑Y ❑P
Sputum ❑Y ❑P
Spitting up blood ❑Y ❑P
Wheezing ❑Y ❑P
Asthma ❑Y ❑P
Bronchitis ❑Y ❑P
Pneumonia ❑Y ❑P
Emphysema ❑Y ❑P
Difficulty breathing ❑Y ❑P
Pain on breathing ❑Y ❑P
Shortness of breath ❑Y ❑P
Tuberculosis ❑Y ❑P
Tuberculin Test ❑Y ❑P
Last Chest X-Ray _____

BREASTS
Do you do self exams ❑Y ❑P
Lumps ❑Y ❑P
Pain/tenderness ❑Y ❑P
Nipple discharge ❑Y ❑P

GASTROINTESTINAL
Trouble swallowing ❑Y ❑P
Heartburn ❑Y ❑P
Change in thirst ❑Y ❑P
Change in appetite ❑Y ❑P
Nausea/Vomiting ❑Y ❑P
Vomiting blood ❑Y ❑P
Blood in stool ❑Y ❑P
Belching/Flatulence ❑Y ❑P
Jaundice (yellow skin) ❑Y ❑P
Liver disease ❑Y ❑P
Gall bladder disease ❑Y ❑P
Ulcer ❑Y ❑P
Indigestion ❑Y ❑P
Diarrhea ❑Y ❑P
Constipation (less than 1 stool/day) ❑Y ❑P
Rectal bleeding ❑Y ❑P
Haemorrhoids ❑Y ❑P
Black, tarry stool ❑Y ❑P
Abdominal pain ❑Y ❑P
Food allergy ❑Y ❑P
Hernias ❑Y ❑P

CARDIOVASCULAR
High blood pressure ❑Y ❑P
Rheumatic fever ❑Y ❑P
Swollen ankles ❑Y ❑P
Chest pain ❑Y ❑P
Palpitations ❑Y ❑P
High cholesterol ❑Y ❑P
Heart murmurs ❑Y ❑P

URINARY
Pain on urination ❑Y ❑P
Increased frequency ❑Y ❑P
Frequency at night ❑Y ❑P
Inability to hold urine ❑Y ❑P
Frequent infections ❑Y ❑P
Kidney stones ❑Y ❑P
Blood in urine ❑Y ❑P
Urgency ❑Y ❑P
Hesitancy ❑Y ❑P

MALE REPRODUCTIVE
Hernias ❑Y ❑P
Testicular masses ❑Y ❑P
Testicular pain ❑Y ❑P
Sexual difficulties ❑Y ❑P
Sexually Transmitted Infection ❑Y ❑P
Discharge/sores ❑Y ❑P
Date of last prostate exam _____

FEMALE REPRODUCTIVE
Age menses began _____
Average number of days _____
Length of cycle _____
Last menstrual period _____
Last PAP test (date) _____
Number of pregnancies _____
Number of miscarriages _____
Number of abortions _____
Are you sexually active ❑Y ❑P
Currently pregnant ❑Y ❑P
Bleeding between periods ❑Y ❑P
Are cycles regular ❑Y ❑P
Pain during intercourse ❑Y ❑P
Painful menses ❑Y ❑P
Excessive flow ❑Y ❑P
PMS ❑Y ❑P
Birth control (and type) ❑Y ❑P

Willow Wellness CLINIC

Difficulty conceiving ❑Y ❑P
Sexual difficulties ❑Y ❑P
Sexually Transmitted Infection ❑Y ❑P
Vaginal discharge ❑Y ❑P
Vaginal itching/dryness ❑Y ❑P

MUSCULOSKELETAL
Joint pain/stiffness ❑Y ❑P
Arthritis/gout ❑Y ❑P
Broken bones ❑Y ❑P
Muscle spasms/cramps ❑Y ❑P
Joint swelling ❑Y ❑P
Backache ❑Y ❑P

PERIPHERAL VASCULAR
Deep leg pain ❑Y ❑P
Cold hands/feet ❑Y ❑P
Varicose veins ❑Y ❑P
Leg cramps ❑Y ❑P
Extremity numbness ❑Y ❑P
Extremity swelling ❑Y ❑P
Extremity ulcers ❑Y ❑P

NEUROLOGIC
Fainting ❑Y ❑P
Seizures/convulsions ❑Y ❑P
Paralysis ❑Y ❑P
Muscle weakness ❑Y ❑P
Numbness/tingling ❑Y ❑P
Loss of memory ❑Y ❑P
Involuntary movement ❑Y ❑P
Loss of balance ❑Y ❑P
Speech problems ❑Y ❑P

ENDOCRINE
Heat/cold intolerance ❑Y ❑P
Thyroid trouble ❑Y ❑P
Excessive thirst/hunger ❑Y ❑P
Excessive urination ❑Y ❑P
Excessive sweating ❑Y ❑P
Diabetes ❑Y ❑P
Hypoglycemia ❑Y ❑P
Hormone therapy ❑Y ❑P

BLOOD/LYMPHATIC
Anemia ❑Y ❑P
Easy bleeding/bruising ❑Y ❑P
Past transfusions ❑Y ❑P
Lymph node swelling ❑Y ❑P

EMOTIONAL
Depression ❑Y ❑P
Mood swings ❑Y ❑P
Anxiety/nervousness ❑Y ❑P
Tension ❑Y ❑P
Phobias ❑Y ❑P
Alcohol/drug use ❑Y ❑P
Insomnia ❑Y ❑P

HOBBIES/HABITS
Do you eat 3 meals per day? ❑Y ❑N
Do you wake well rested? ❑Y ❑N
Do you sleep well? ❑Y ❑N
Do you average 6-8 hours sleep? ❑Y ❑N
Do you enjoy your work? ❑Y ❑N
Do you exercise? ❑Y ❑N

How many hours/day? _____