

## INFORMED CONSENT FORM

By signing below, I do hereby voluntarily consent to be treated with Acupuncture and/or any modality under this scope of practice. I further understand that Acupuncturist in the state of Florida are considered primary healthcare providers, however, care by a licensed medical doctor is highly recommended.

**Acupuncture:** I understand that acupuncture is performed by the insertion of sterile needles through the skin or by the application of heat to the skin (or body) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may occur. These could include, but are not limited to; local bruising, mild bleeding, fainting, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop treatment at any time.

**Herbs:** I understand that herbs, minerals and vitamin supplements may be recommended to me to treat bodily dysfunction and diseases, to modify or prevent pain perception, and to normalize the body's physiological function. I understand that I am not required to take these substances, but must follow the directions for administration and dosages if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to; changes in bowel movements, abdominal pain or discomfort and the possible aggravation of symptoms existing prior to herbal treatment. **Should I experience any problems which I associate with these substances I will stop taking them and contact Essential Bodyworks as soon as possible.**

**Injection Therapy;** I understand that herbs, vitamins and/or homeopathic remedies that are injected into the skin may be recommended to me to treat bodily dysfunction or disease. I understand that I am not required to accept this procedure, but if I do, I understand that certain adverse side effects may occur. These side effects include, but are not limited to, soreness at site of injection, pain, redness of skin, swelling, minor bleeding and bruising.

**Tui-na, massage and cupping;** I understand that I may also be offered tui-na, massage and/or cupping therapy to modify or prevent pain perception and to normalize the body's physiological functions. I am aware the certain adverse side effects may occur. These side effects include, but are not limited to, bruising, sore or achy muscles, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable or painful.

I understand that there may be other treatment alternatives, including treatment by a licensed physician.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my acupuncturist for more detailed information. I give my permission and consent to treatment.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Phone** \_\_\_\_\_

# PATIENT INFORMATION FORM

Benjamin McCluske, Acupuncture Physician, Licensed Massage Therapist  
DBA Essential Bodyworks

Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Work Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Would you like to receive email updates / special offers? Yes \_\_\_\_\_ No \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

How were you referred?  
(Check one)

by Chiropractor

by Medical Doctor

by Naturopath

by Friend or Relative

Advertisement

Seminar

Other \_\_\_\_\_

## CONTACT QUESTIONARE

1. Please list the Family members or other persons, if any, whom we may inform about you general medical conditions and your diagnosis (including treatment, payment and healthcare operation).

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2. Please list the Family members or significant others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

3. Please print the telephone number(s) where you want to receive calls about your appointments, lab and x ray results, or other healthcare information:

\_\_\_\_\_  
\_\_\_\_\_

Check one:

\_\_\_\_ O.K. to leave message with detailed information

\_\_\_\_ Leave message with callback number only

**It is the responsibility of the patient to notify Benjamin McCluske, DBA Essential Bodyworks if this information should change.**

Patient Name \_\_\_\_\_ (guardian if under 18 years)  
(Please print)

\_\_\_\_\_  
Patient/ guardian (signature)

\_\_\_\_\_  
Date

# PATIENT INTAKE FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

**NOW:**  PREGNANT  PACEMAKER  AIDS  HEPATITIS  BLOOD TRANSFUSION

**FAMILY HISTORY:**

- Abuse  AIDS  Alcoholism  Allergies  Asthma  Cancer  Diabetes
- Drugs  Heart Disease  High Blood Pressure  Respiratory Diseases  Seizures
- Stroke  Other \_\_\_\_\_

**YOUR PAST MEDICAL HISTORY/ILLNESSES:**

- Aids  Alcoholism  Arthritis  Asthma  Auto Immune Disease  Bronchitis  Cancer
- Chronic Fatigue Syndrome  Chronic Lung Disease  Diabetes  Drugs  Heart Disease
- Hepatitis  Hernia  High Blood Pressure  Kidney Disease  Organ Transplant  Pneumonia
- Rheumatic Fever  Seizures/Epilepsy  Sexually Transmitted Diseases (STD) \_\_\_\_\_
- Thyroid Disease  Tuberculosis  Ulcers  Vaccine Reaction  Whooping Cough

**SURGERIES: (Please include dates)**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**TRAUMATIC INJURY: (Please include dates)**

- Car accident \_\_\_\_\_
- Falls \_\_\_\_\_
- Other \_\_\_\_\_

**ALLERGIES:**

- Drugs \_\_\_\_\_
- Chemicals \_\_\_\_\_
- Food \_\_\_\_\_
- Others \_\_\_\_\_

**CURRENT MEDICATIONS:**

**OCCUPATIONAL/ENVIRONMENTAL EXPOSURES OR HAZARDS:**

- Chemical: \_\_\_\_\_ Acid/Alkalines: \_\_\_\_\_
- Heavy Metals: \_\_\_\_\_ Physical Labor: \_\_\_\_\_
- Electrical: \_\_\_\_\_ Psychological: \_\_\_\_\_

**HABITS/EXCESSIVE USAGE:**

- alcohol  chocolate  cigarettes  coffee  cola  drugs  exercise  food  salt
- sex  sugar  tea  other \_\_\_\_\_

**CHIEF COMPLAINT / REASON FOR COMING IN:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## GENERAL

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> poor appetite      | <input type="checkbox"/> insomnia             | <input type="checkbox"/> vertigo        | <i>Energy level:</i> <input type="checkbox"/> high <input type="checkbox"/> moderate <input type="checkbox"/> low |
| <input type="checkbox"/> change in appetite | <input type="checkbox"/> hours of sleep _____ | <input type="checkbox"/> edema          | <i>Thirsty, desires:</i> <input type="checkbox"/> hot <input type="checkbox"/> cold                               |
| <input type="checkbox"/> large appetite     | <input type="checkbox"/> easy to fall asleep  | <input type="checkbox"/> bleeds easily  | <input type="checkbox"/> room temp. <input type="checkbox"/> no desire  |
| <input type="checkbox"/> cravings           | <input type="checkbox"/> heavy sleeper        | <input type="checkbox"/> bruises easily | <i>Coldness:</i> <input type="checkbox"/> hands <input type="checkbox"/> feet <input type="checkbox"/> back       |
| <input type="checkbox"/> weight gain        | <input type="checkbox"/> light sleeper        | <input type="checkbox"/> fatigue/tired  | <i>Heat:</i> <input type="checkbox"/> hands <input type="checkbox"/> feet <input type="checkbox"/> solar plexus   |
| <input type="checkbox"/> weight loss        | <input type="checkbox"/> dream disturbance    | <input type="checkbox"/> sudden drop    | <input type="checkbox"/> abdomen <input type="checkbox"/> whole body  |
| <input type="checkbox"/> fevers             | <input type="checkbox"/> hard to fall back    | <input type="checkbox"/> in energy      | <i>Stiffness:</i> <input type="checkbox"/> joints <input type="checkbox"/> back <input type="checkbox"/> limbs    |
| <input type="checkbox"/> chills             | <input type="checkbox"/> asleep               | <i>Are you taking:</i>                  | <i>Intolerance to:</i> <input type="checkbox"/> hot <input type="checkbox"/> cold <input type="checkbox"/> wind   |
| <input type="checkbox"/> sweating           | <input type="checkbox"/> tremors/shaking      | <input type="checkbox"/> Aspirin        | <input type="checkbox"/> fan <input type="checkbox"/> A/C   |
| <input type="checkbox"/> night sweats       | <input type="checkbox"/> dizziness            | <input type="checkbox"/> Blood Thinners | <i>Pain:</i> <input type="checkbox"/> upper back <input type="checkbox"/> lower back                              |
| <input type="checkbox"/> sweats easily      | <input type="checkbox"/> poor coordination    | <input type="checkbox"/> Vitamins       | <input type="checkbox"/> upper limbs <input type="checkbox"/> lower limbs   |
| <input type="checkbox"/> headache           |   | <input type="checkbox"/> Herbs          | <input type="checkbox"/> whole body   |
|   |   | <input type="checkbox"/> Supplements    | <i>Rate the pain:</i> Scale 1-10 (10 worst) _____   |

## SKIN AND HAIR

- |  |                                       |   |   |
|--|---------------------------------------|---|---|
| <input type="checkbox"/> rashes  | <input type="checkbox"/> psoriasis    | <input type="checkbox"/> itching                | <input type="checkbox"/> thinning of hair     |
| <input type="checkbox"/> eczema  | <input type="checkbox"/> eruptions    | <input type="checkbox"/> sweating               | <input type="checkbox"/> change in hair       |
| <i>skin:</i> <input type="checkbox"/> dry <input type="checkbox"/> moist | <input type="checkbox"/> discharge    | <input type="checkbox"/> change in skin texture | <input type="checkbox"/> other hair problems: |
| <input type="checkbox"/> sores   | <input type="checkbox"/> pimples/acne | <input type="checkbox"/> dandruff               | _____   |
| <input type="checkbox"/> ulcers  | <input type="checkbox"/> bruises      | <input type="checkbox"/> loss of hair           | <input type="checkbox"/> other skin problems: |
| <input type="checkbox"/> herpes  | <input type="checkbox"/> hives        | <input type="checkbox"/> balding                | _____   |

## HEAD, EYES, EARS, NOSE, MOUTH & THROAT

- | <u>Head</u>                               | <u>Eyes (R/L)</u>                              | <u>Ears (R/L)</u>   | <u>Nose</u>   | <u>Mouth</u>                            | <u>Throat</u>                                     |
|---|--|---|---|---|---|
| <input type="checkbox"/> dizziness        | <input type="checkbox"/> cataract/<br>glaucoma | <input type="checkbox"/> loss of hearing                    | <input type="checkbox"/> loss of smell                        | <input type="checkbox"/> grind teeth    | <input type="checkbox"/> dry throat               |
| <input type="checkbox"/> migraine         | <input type="checkbox"/> eye pain              | <input type="checkbox"/> discharge                          | <input type="checkbox"/> good sense of smell                  | <input type="checkbox"/> drooling       | <input type="checkbox"/> hoarseness               |
| <i>Headaches:</i>                         | <input type="checkbox"/> twitching             | <input type="checkbox"/> earaches                           | <input type="checkbox"/> nose bleeds                          | <input type="checkbox"/> excess saliva  | <input type="checkbox"/> recurrent<br>sore throat |
| <input type="checkbox"/> frontal          | <input type="checkbox"/> floaters/spots        | <input type="checkbox"/> poor hearing                       | <input type="checkbox"/> allergies                            | <input type="checkbox"/> dry mouth      | <input type="checkbox"/> loss of voice            |
| <input type="checkbox"/> temporal         | <input type="checkbox"/> poor vision           | <input type="checkbox"/> itchiness                          | <input type="checkbox"/> nasal discharge                      | <input type="checkbox"/> gum disease    | <input type="checkbox"/> difficulty<br>swallowing |
| <input type="checkbox"/> vertex           | <input type="checkbox"/> blurry vision         | <i>Ring in ears:</i>  | <i>color:</i> <input type="checkbox"/> yellow                 | <input type="checkbox"/> bad breath     | <input type="checkbox"/> lump in<br>throat        |
| <input type="checkbox"/> occipital        | <input type="checkbox"/> night blindness       | <input type="checkbox"/> loud <input type="checkbox"/> soft | <input type="checkbox"/> white <input type="checkbox"/> clear | <input type="checkbox"/> gum bleeding   | <input type="checkbox"/> frequent<br>tonsillitis  |
| <input type="checkbox"/> head injury      | <input type="checkbox"/> itchiness             | <input type="checkbox"/> high pitch                         | <input type="checkbox"/> green                                | <input type="checkbox"/> gum swelling   |   |
| <input type="checkbox"/> facial pain      | <input type="checkbox"/> glasses/contacts      | <input type="checkbox"/> low pitch                          | <i>amount:</i> <input type="checkbox"/> scanty                | <input type="checkbox"/> taste in mouth |   |
| <input type="checkbox"/> facial paralysis | <input type="checkbox"/> red eyes              | <input type="checkbox"/> inflammation                       | <input type="checkbox"/> mod <input type="checkbox"/> heavy   | <input type="checkbox"/> ulcers         |   |
| <input type="checkbox"/> sinus problems   |  | <input type="checkbox"/> tenderness                         | <input type="checkbox"/> thick <input type="checkbox"/> thin  | <input type="checkbox"/> sores          |   |
| other: _____                              | other: _____                                   | other: _____  | other: _____  | other: _____                            | other: _____                                      |

## CARDIOVASCULAR

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> chest pain           | <input type="checkbox"/> difficulty in breathing | <input type="checkbox"/> coma                  |
| <input type="checkbox"/> low blood pressure  | <input type="checkbox"/> cold hands/feet      | <input type="checkbox"/> shortness of breath     | <input type="checkbox"/> loss of consciousness |
| <input type="checkbox"/> dizziness           | <input type="checkbox"/> swelling hands/feet  | <input type="checkbox"/> dream disturbance       | other: _____                                   |
| <input type="checkbox"/> fainting            | <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> poor memory             |  |
| <input type="checkbox"/> palpitations        | <input type="checkbox"/> insomnia             | <input type="checkbox"/> mania/delirium          |  |

## RESPIRATORY

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> pneumonia      | <i>cough:</i> how long? _____   | <input type="checkbox"/> shortness of breath                         |
| <input type="checkbox"/> bronchitis     | <input type="checkbox"/> dry <input type="checkbox"/> croup <input type="checkbox"/> rapid <input type="checkbox"/> other | <input type="checkbox"/> fullness in chest                           |
| <input type="checkbox"/> asthma         | <i>phlegm:</i> <input type="checkbox"/> thin <input type="checkbox"/> thick <input type="checkbox"/> clear                | <i>difficulty breathing:</i>   |
| <input type="checkbox"/> coughing blood | <input type="checkbox"/> white <input type="checkbox"/> yellow <input type="checkbox"/> green                             | <input type="checkbox"/> sitting <input type="checkbox"/> lying down |
| <input type="checkbox"/> wheezing       | <input type="checkbox"/> tightness in chest   | <input type="checkbox"/> other chest discomfort                      |

## GASTROINTESTINAL

- |   |   |  |   |  |
|---|---|--|---|--|
| <input type="checkbox"/> food allergies   | <input type="checkbox"/> taste in mouth | <input type="checkbox"/> loose stools            | <input type="checkbox"/> difficult stools | <input type="checkbox"/> tenderness in abdomen |
| <input type="checkbox"/> vomiting         | <input type="checkbox"/> belching       | <input type="checkbox"/> bloody/black stools     | <input type="checkbox"/> mucus in stools  | <input type="checkbox"/> fullness in abdomen   |
| <input type="checkbox"/> cramping         | <input type="checkbox"/> bad breath     | <input type="checkbox"/> ulcers                  | <input type="checkbox"/> hemorrhoids      | <input type="checkbox"/> burning in abdomen    |
| <input type="checkbox"/> gas              | <input type="checkbox"/> hiccup         | <input type="checkbox"/> increased appetite      | <input type="checkbox"/> hernia           | <input type="checkbox"/> like/dislike pressure |
| <input type="checkbox"/> abd/stomach pain | <input type="checkbox"/> constipation   | <input type="checkbox"/> poor appetite           | <input type="checkbox"/> rectal pain      | <input type="checkbox"/> like/dislike cold     |
| <input type="checkbox"/> nausea           | <input type="checkbox"/> diarrhea       | <input type="checkbox"/> hungry-no desire to eat | <input type="checkbox"/> rectal bleeding  | <input type="checkbox"/> like/dislike warmth   |

## GENITO-URINARY

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> burning /painful urine                      | <input type="checkbox"/> poor stream/scanty urine | <input type="checkbox"/> diminished sex drive | <input type="checkbox"/> discharge                     |
| color: <input type="checkbox"/> cloudy <input type="checkbox"/> pale | <input type="checkbox"/> dribbling urine          | <input type="checkbox"/> increased sex drive  | <input type="checkbox"/> history of kidney stones      |
| <input type="checkbox"/> dk yellow <input type="checkbox"/> pink/red | <input type="checkbox"/> unable to urinate        | <input type="checkbox"/> impotency            | <input type="checkbox"/> history of bladder infections |
| <input type="checkbox"/> unable to hold urine                        | <input type="checkbox"/> frequent urination       | <input type="checkbox"/> genital itching      | <input type="checkbox"/> history of prostate problems  |
| <input type="checkbox"/> wakes up to urinate                         | <input type="checkbox"/> urgency to urinate       | <input type="checkbox"/> genital sores/pain   | <input type="checkbox"/> history of STD                |

## MUSCULO-SKELETAL

- |  |                     |   |                                    |                                   |                                   |                                   |
|--|---------------------|---|------------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> joint pain      | <i>upper limbs:</i> | <input type="checkbox"/> pain <input type="checkbox"/> swelling | <input type="checkbox"/> burning   | <input type="checkbox"/> weakness | <input type="checkbox"/> numbness | <input type="checkbox"/> tingling |
|  |                     | <input type="checkbox"/> tenderness                             | <input type="checkbox"/> stiffness |                                   |                                   |                                   |
| <input type="checkbox"/> joint swelling  | <i>lower limbs:</i> | <input type="checkbox"/> pain <input type="checkbox"/> swelling | <input type="checkbox"/> burning   | <input type="checkbox"/> weakness | <input type="checkbox"/> numbness | <input type="checkbox"/> tingling |
|  |                     | <input type="checkbox"/> tenderness                             | <input type="checkbox"/> stiffness |                                   |                                   |                                   |
| <input type="checkbox"/> joint stiffness | <i>back:</i>        | <input type="checkbox"/> pain <input type="checkbox"/> swelling | <input type="checkbox"/> burning   | <input type="checkbox"/> weakness | <input type="checkbox"/> numbness | <input type="checkbox"/> tingling |
|  |                     | <input type="checkbox"/> tenderness                             | <input type="checkbox"/> stiffness |                                   |                                   |                                   |
| <input type="checkbox"/> sciatica        | <i>neck:</i>        | <input type="checkbox"/> pain <input type="checkbox"/> swelling | <input type="checkbox"/> burning   | <input type="checkbox"/> weakness | <input type="checkbox"/> numbness | <input type="checkbox"/> tingling |
|  |                     | <input type="checkbox"/> tenderness                             | <input type="checkbox"/> stiffness |                                   |                                   |                                   |

## NEUROPHYSIOLOGICAL

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> history of emotional problems | <input type="checkbox"/> melancholy       | <input type="checkbox"/> joyful        | <input type="checkbox"/> tremors/shaking                                    |
| <input type="checkbox"/> depression                    | <input type="checkbox"/> grieving         | <input type="checkbox"/> giddy         | <input type="checkbox"/> convulsions  |
| <input type="checkbox"/> anxiety                       | <input type="checkbox"/> easy to anger    | <input type="checkbox"/> over-thinking | <input type="checkbox"/> coma   |
| <input type="checkbox"/> easily stressed               | <input type="checkbox"/> irritability     | <input type="checkbox"/> talkative     | <input type="checkbox"/> concussion   |
| <input type="checkbox"/> confusion/foggy               | <input type="checkbox"/> restlessness     | <input type="checkbox"/> silent        | <input type="checkbox"/> paralysis  |
| <input type="checkbox"/> lack of clarity               | <input type="checkbox"/> emotional        | <input type="checkbox"/> extrovert     | <input type="checkbox"/> trauma at birth                                    |
| <input type="checkbox"/> moody                         | <input type="checkbox"/> frequent sighing | <input type="checkbox"/> introvert     | <input type="checkbox"/> vaginal delivery <input type="checkbox"/> cesarean |
| <input type="checkbox"/> fear/fright                   | <input type="checkbox"/> over-worried     | <input type="checkbox"/> poor memory   | <input type="checkbox"/> considered/attempted suicide                       |
| <input type="checkbox"/> hyper                         | <input type="checkbox"/> bad-tempered     | <input type="checkbox"/> seizures      | <input type="checkbox"/> unable to focus                                    |
|  |   |  | <input type="checkbox"/> phobia _____                                       |

## GYNECOLOGY AND PREGNANCY [Last Menstrual Period \_\_\_\_\_ Last PAP \_\_\_\_\_]

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> no. of pregnancies _____      | <input type="checkbox"/> age at first menses _____  | <input type="checkbox"/> fibroids  | color: <input type="checkbox"/> lt. red <input type="checkbox"/> red |
| <input type="checkbox"/> no. of live births _____      | <input type="checkbox"/> length of period _____   | <input type="checkbox"/> abd. Bloating/fullness  | <input type="checkbox"/> dk red <input type="checkbox"/> dk purple   |
| <input type="checkbox"/> no. of miscarriages _____     | <input type="checkbox"/> number of days in cycle _____  | <input type="checkbox"/> pain with stools  | clots: <input type="checkbox"/> large <input type="checkbox"/> small |
| <input type="checkbox"/> no. of premature births _____ | <input type="checkbox"/> early menstrual cycle (less than 21 days)                                    | <input type="checkbox"/> mood change before period   | vaginal discharge:   |
| <input type="checkbox"/> no. of abortions _____        | <input type="checkbox"/> late menstrual cycle (less than 35 days)                                     | <input type="checkbox"/> body change before period   | <input type="checkbox"/> odor <input type="checkbox"/> no odor       |
| <input type="checkbox"/> infertility                   | <input type="checkbox"/> irregular menstrual cycle  | <i>menstrual pain/cramps:</i>  | <input type="checkbox"/> watery <input type="checkbox"/> thick       |
| <input type="checkbox"/> pain during intercourse       | <input type="checkbox"/> <i>menopause:</i> <input type="checkbox"/> pre <input type="checkbox"/> post | <input type="checkbox"/> before <input type="checkbox"/> during <input type="checkbox"/> after | <input type="checkbox"/> curdy <input type="checkbox"/> itchy        |
| <input type="checkbox"/> uterine prolapse              | <input type="checkbox"/> age at menopause _____   | <input type="checkbox"/> days of heavy flow _____  | color: <input type="checkbox"/> clear <input type="checkbox"/> white |
| <i>birth control pills:</i>                            | <input type="checkbox"/> history of ovarian cysts   | <input type="checkbox"/> endometriosis   | <input type="checkbox"/> yellow <input type="checkbox"/> bloody      |
| type _____   | <input type="checkbox"/> history of uterine problems  | <i>flow:</i> <input type="checkbox"/> thick <input type="checkbox"/> thin                      | <input type="checkbox"/> vaginal burning/itching                     |
| how long? _____  |   | <i>amount:</i> <input type="checkbox"/> scanty <input type="checkbox"/> mod                    | <input type="checkbox"/> vaginal pain                                |
|  |   | <input type="checkbox"/> heavy <input type="checkbox"/> very heavy                             | <input type="checkbox"/> vaginal sores                               |

## BREAST

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> history of breast disease | <input type="checkbox"/> breast tenderness        | <i>breast discharge:</i> <input type="checkbox"/> clear <input type="checkbox"/> white <input type="checkbox"/> yellow <input type="checkbox"/> green      |
| <input type="checkbox"/> breast lumps/masses       | <input type="checkbox"/> breast fullness/swelling | <input type="checkbox"/> black <input type="checkbox"/> blood <input type="checkbox"/> watery <input type="checkbox"/> thin <input type="checkbox"/> thick |
| <input type="checkbox"/> history of breast cancer  | <input type="checkbox"/> breast pain              | other: _____   |