



CONFIDENTIAL HEALTH QUESTIONNAIRE

PATIENT INFORMATION - IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK

Services in our office are delivered in a manner that goes above and beyond those found in any other office. Part of this service is a thorough, all-inclusive history. Please provide the requested information so that we can help you to the best of our ability.

PATIENT INFORMATION

FULL NAME: _____ DATE OF BIRTH: ____ / ____ / ____ AGE: _____
 NAME YOU WOULD LIKE TO BE CALLED, IF DIFFERENT: _____ SSN: _____ - _____ - _____ M F
 ADDRESS: _____ APT #: _____ HOME PH: _____
 CITY: _____ STATE: _____ ZIP: _____ CELL PH: _____
 MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED OTHER _____ # of Children: _____
 SPOUSE / PARTNER'S NAME: _____ EMERGENCY CONTACT #: _____
 EMAIL ADDRESS: _____

It is imperative that we have a current email address for all of our patients. This is how we do most of our Office/Patient communication.

REFERRAL SOURCE: The majority of our practice members come from referrals.

WERE YOU REFERRED BY A PATIENT OF OURS? YES NO PATIENT NAME: _____
 WERE YOU REFERRED BY YOUR MD? IF SO, WHO? _____
 IF YOU WERE NOT REFERRED BY A PATIENT OR YOUR MD, HOW DID YOU **FIRST** HEAR ABOUT US? FRIEND/FAMILY DRIVE-BY/SIGN MAIL
 CHAMBER MAGAZINE WEBSITE/DRDURRETT.COM ONLINE SEARCH, i.e. GOOGLE OTHER _____
 I WILL BE PAYING TODAY BY: CASH CHECK CREDIT CARD HEALTH INSURANCE
 AUTOMOBILE INSURANCE WORKER'S COMPENSATION

EMPLOYMENT

EMPLOYER'S NAME: _____ WORK PHONE: _____
 OCCUPATION: _____ EMPLOYMENT STATUS: FULL TIME PART TIME RETIRED UNEMPLOYED

INSURANCE INFORMATION

INSURED'S NAME: _____ RELATIONSHIP? SELF SPOUSE CHILD OTHER _____
 INSURED'S EMPLOYER: SAME AS ABOVE OTHER: _____
 INSURED'S SSN: SAME AS ABOVE _____ - _____ - _____ INSURED'S DOB: SAME AS ABOVE ____ / ____ / ____
PRIMARY INSURANCE CO. _____ ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____ PHONE #: _____
 POLICY #: _____ GROUP #: _____
SECONDARY INSURANCE CO. _____ ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____ PHONE #: _____
 POLICY #: _____ GROUP #: _____

WHAT BROUGHT YOU TO OUR OFFICE TODAY?

PLEASE DESCRIBE PRESENT MAJOR COMPLAINT OR HEALTH ISSUES:

PLEASE RATE YOUR SYMPTOMS OF PAIN OR DISCOMFORT (1-10, WITH 1 LEAST SERIOUS)

1. _____ DISCOMFORT / PAIN LEVEL: _____ ONSET DATE: _____
2. _____ DISCOMFORT / PAIN LEVEL: _____ ONSET DATE: _____
3. _____ DISCOMFORT / PAIN LEVEL: _____ ONSET DATE: _____
4. _____ DISCOMFORT / PAIN LEVEL: _____ ONSET DATE: _____

REGARDING YOUR MAIN COMPLAINT:

SYMPTOMS DEVELOPED FROM: AN AUTO ACCIDENT ON: _____ A JOB RELATED INJURY ON: _____ AN INJURY ON: _____
 AN ILLNESS GRADUAL ONSET AN UNKNOWN ORIGIN

SYMPTOMS HAVE PERSISTED FOR: _____ SYMPTOMS ARE WORSE IN: THE MORNING EVENING UNCHANGED
SYMPTOMS: COME & GO ARE CONSTANT ARE NEARLY CONSTANT AFTERNOON CONSISTENT

SELF & FAMILY HISTORY: (S = SELF, M = MOTHER, F = FATHER)

S M F AIDS	S M F DEPRESSION	S M F IS DECEASED	S M F REPRODUCTIVE DISORDER
S M F ALLERGIES	S M F DIABETES	S M F KIDNEY DISORDER	
S M F ANEMIA	S M F DIARRHEA	S M F LOSS OF BOWEL CONTROL	S M F RHEUMATIC FEVER
S M F ARTHRITIS	S M F DIGESTIVE DISORDER	S M F LUNG DISEASE	S M F RHEUMATISM
S M F ASTHMA	S M F DISLOCATED JOINTS	S M F MENSTRUAL CRAMPS	S M F SCARLET FEVER
S M F BACK PAIN	S M F EPILEPSY	S M F MULTIPLE SCLEROSIS	S M F SERIOUS INJURY
S M F BLADDER TROUBLE	S M F FIBROMYALGIA	S M F MUSCULAR DYSTROPHY	S M F SINUS TROUBLE
S M F BONE FRACTURE	S M F GERMAN MEASLES	S M F NECK PAIN	S M F TUBERCULOSIS
S M F CANCER	S M F HEADACHES	S M F NERVOUSNESS	S M F VENEREAL DISEASE
S M F CHEST PAIN	S M F HEART TROUBLE	S M F NONE STATED	S M F ADD / ADHD
S M F CONCUSSION	S M F HEPATITIS	S M F NUMBNESS	S M F ADRENAL FATIGUE
S M F CONSTIPATION	S M F HIGH BLOOD PRESSURE	S M F OSTEOPOROSIS	S M F BLOOD SUGAR ISSUES
S M F CONVULSIONS	S M F HIGH CHOLESTEROL	S M F POLIO	S M F TOXICITY ISSUES
S M F DECEASED	S M F HIV / ARC	S M F POOR CIRCULATION	

ACTIVITIES THAT AGGRAVATE:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> BENDING | <input type="checkbox"/> LIFTING | <input type="checkbox"/> SITTING AFTER _____ MINUTES | <input type="checkbox"/> TURNING HEAD |
| <input type="checkbox"/> COUGHING | <input type="checkbox"/> LYING DOWN | <input type="checkbox"/> SNEEZING | <input type="checkbox"/> TWISTING INJURED AREA |
| <input type="checkbox"/> DRIVING | <input type="checkbox"/> OVERHEAD ACTIVITIES | <input type="checkbox"/> STANDING | <input type="checkbox"/> WALKING |
| <input type="checkbox"/> EXERCISING | <input type="checkbox"/> PREPARING FOOD | <input type="checkbox"/> STANDING _____ MINUTES | <input type="checkbox"/> WALKING AFTER _____ MINUTES |
| <input type="checkbox"/> GETTING UP & DOWN | <input type="checkbox"/> REACHING | <input type="checkbox"/> STANDING STRAIGHT | |
| <input type="checkbox"/> INCREASED ACTIVITY IN GENERAL | <input type="checkbox"/> SITTING | <input type="checkbox"/> STRAINING AT STOOL | <input type="checkbox"/> OTHER _____ |

ACTIVITIES / ITEMS THAT RELIEVE

- | | | | | | | |
|----------------------------------|----------------------------------|-------------------------------------|-----------------------------------|-------------------------------------|---------------------------------------|----------------------------------|
| <input type="checkbox"/> BENDING | <input type="checkbox"/> ICE | <input type="checkbox"/> LYING DOWN | <input type="checkbox"/> REACHING | <input type="checkbox"/> SITTING | <input type="checkbox"/> STANDING | <input type="checkbox"/> WALKING |
| <input type="checkbox"/> HEAT | <input type="checkbox"/> LIFTING | <input type="checkbox"/> MEDICATION | <input type="checkbox"/> RESTING | <input type="checkbox"/> STRETCHING | <input type="checkbox"/> TURNING HEAD | |

ADDITIONAL SYMPTOMS:

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> BLURRED VISION | <input type="checkbox"/> FACE FLUSHED | <input type="checkbox"/> LOW RESISTANCE TO COLDS | <input type="checkbox"/> STIFF NECK |
| <input type="checkbox"/> BUZZING IN EARS | <input type="checkbox"/> FAINTING | <input type="checkbox"/> MUSCLE JERKING | <input type="checkbox"/> STOMACH UPSET |
| <input type="checkbox"/> COLD FEET | <input type="checkbox"/> FATIGUE | <input type="checkbox"/> NONE | <input type="checkbox"/> STRESS |
| <input type="checkbox"/> COLD HANDS | <input type="checkbox"/> FEVER | <input type="checkbox"/> NUMBNESS IN FINGERS | <input type="checkbox"/> CHEMICAL SENSITIVITY |
| <input type="checkbox"/> COLD SWEATS | <input type="checkbox"/> HEAD SEEMS TOO HEAVY | <input type="checkbox"/> NUMBNESS IN TOES | <input type="checkbox"/> DIFFICULTY SLEEPING |
| <input type="checkbox"/> CONFUSION | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> PINS & NEEDLES IN ARMS | <input type="checkbox"/> WEIGHT GAIN / LOSS |
| <input type="checkbox"/> CONCENTRATION LOSS | <input type="checkbox"/> INSOMNIA | <input type="checkbox"/> PINS & NEEDLES IN LEGS | <input type="checkbox"/> THYROID ISSUES |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> LIGHT BOTHERS EYES | <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> WEEPING SPELLS |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> LOSS OF BALANCE | <input type="checkbox"/> SENSITIVITY TO COLD / DAMP WEATHER | |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> LOSS OF SMELL | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> LOSS OF TASTE | | |

HOW DO YOU GRADE YOUR **PHYSICAL** HEALTH? EXCELLENT GOOD FAIR POOR GETTING BETTER GETTING WORSE
AND YOUR **EMOTIONAL / MENTAL** HEALTH? EXCELLENT GOOD FAIR POOR GETTING BETTER GETTING WORSE

IF YOU CONSIDER YOURSELF ILL, WHY DO YOU FEEL THAT YOU ARE ILL? _____

IF YOU CONSIDER YOURSELF WELL, WHY DO YOU FEEL THAT YOU ARE WELL? _____

The AMA has found that more than 80% of all health problems are due to stress. Stress affects the nervous system. In our practice, we are interested in evaluating and examining stresses your body can not properly perceive, adapt to or recover from.

These stresses may be PHYSICAL, CHEMICAL or EMOTIONAL/MENTAL in nature.

PHYSICAL STRESS: Please check "P" for Past, "C" for Current (or both if they apply)

FALLS FROM CRIB / BED P C FALLS DOWN / UP STEPS P C FALLS ON ICE P C
SPORTS IMPACTS P C PHYSICAL FIGHTS P C ARMED SERVICES P C

HAVE YOU BEEN KNOCKED UNCONSCIOUS? YES NO EXPLAIN: _____

HAVE YOU EVER USED CRUTCHES, A WALKER OR A CANE? YES NO EXPLAIN: _____

HAVE YOU EVER BROKEN ANY BONES? YES NO EXPLAIN: _____

HAVE YOU EVER HAD ANY IMPACTS, FALLS OR JOLTS THAT YOU FEEL SPECIFICALLY MAY HAVE INJURED YOUR SPINE? YES NO

EXPLAIN: _____

HAVE YOU EVER HAD ANY EXTENSIVE DENTAL OR ORTHODONTIAL WORK DONE? YES NO

EXPLAIN: _____

AUTOMOBILE ACCIDENTS: HAVE YOU (EVEN AS A PASSENGER AND EVEN IF YOU DO NOT THINK YOU WERE HURT) BEEN INVOLVED IN A VEHICULAR COLLISION OR NEAR COLLISION? PLEASE LIST APPROXIMATE DATES AND SEVERITY (MILD, MODERATE, SEVERE OR EXTREME).

AUTOMOBILE: _____

BUS, BICYCLE, MOTORCYCLE, TRAIN, AIRPLANE, MO-PED OR OTHER VEHICLES: _____

SPORTS & LEISURE

IN THE PAST, WERE YOU ACTIVE IN SPORTS? YES NO WHICH ONE(S)? _____

ARE YOU CURRENTLY ACTIVE IN SPORTS? YES NO WHICH ONE(S)? _____

HAVE YOU BEEN HURT IN ANY OF THESE ACTIVITIES? YES NO WHEN? _____

DO YOU READ FOR PROLONGED PERIODS? YES NO DO YOU PLAY A MUSICAL INSTRUMENT? YES NO

DO YOU HAVE A PARTICULAR POSITION FOR WATCHING TV OR READING? YES NO DETAILS: _____

DO YOU WEAR: GLASSES BIFOCALS TRIFOCALS CONTACT LENSES N/A OTHER _____

MEDICAL TREATMENT

HAVE YOU EVER BEEN HOSPITALIZED? YES NO WHEN? _____

IF YES, WHY? _____ WHAT WAS ACTUALLY DONE TO YOU? _____

PLEASE LIST YOUR LAST KNOWN: WEIGHT _____ lbs HEIGHT _____ ft _____ in BLOOD PRESSURE ____ / ____

SURGICAL HISTORY (CONDITION):

1. _____ WHEN: _____

2. _____ WHEN: _____

3. _____ WHEN: _____

ACCIDENT HISTORY

JOB AUTO OTHER 1. _____ WHEN: _____

JOB AUTO OTHER 2. _____ WHEN: _____

JOB AUTO OTHER 3. _____ WHEN: _____

DO YOU STILL HAVE ALL YOUR BODY PARTS? YES NO IF NO, PLEASE EXPLAIN: _____

HAVE YOU HAD: A SPINAL TAP PHYSIOTHERAPY NECK COLLAR SPINAL BRACE TRACTION HEEL LIFT
 SPINAL INJECTIONS RADIATION TREATMENTS CORRECTIVE SHOES OR BARS ON SHOES EXTENSIVE DIAGNOSTIC X-RAYS

HAVE YOU BEEN TREATED BY A PHYSICIAN FOR ANY HEALTH CONDITION IN THE LAST YEAR? Yes No DATE: _____

DESCRIBE CONDITION: _____

EVER HAD A METAL IMPLANT? YES NO

EVER BEEN GUNSHOT? YES NO

EMOTIONAL / MENTAL STRESS:

FOR EACH OF THE FOLLOWING POTENTIAL SPINAL STRESS SITUATIONS, PLEASE CHECK "P" for Past, "C" for Current (or both if they apply) UNDER THE LEVEL OF TRAUMA SEVERITY.

	<i>MILD MODERATE EXTREME</i>				<i>MILD MODERATE EXTREME</i>		
	P	C			P	C	
CHILDHOOD STRESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WORK RELATED STRESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SCHOOL STRESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	STRESS OF COMMUTING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PLAY OR RECREATIONAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LOSS OF A LOVED ONE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FAMILY STRESS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHANGE IN LIFESTYLE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PERSONAL RELATIONSHIPS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHANGE IN VOCATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STRESS OF BEING SICK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CHEMICAL STRESS:

ARE YOU NOW TAKING ANY DRUG (PRESCRIPTION, OVER-THE-COUNTER OR RECREATIONAL) REGULARLY?

DRUG: _____	DATE PRESCRIBED: _____	REASON: _____
DRUG: _____	DATE PRESCRIBED: _____	REASON: _____
DRUG: _____	DATE PRESCRIBED: _____	REASON: _____
DRUG: _____	DATE PRESCRIBED: _____	REASON: _____
DRUG: _____	DATE PRESCRIBED: _____	REASON: _____

DO YOU CONSUME: **D** - CONSUME DAILY, **W** - CONSUME WEEKLY, **M** - CONSUME MONTHLY)

	D	W	M		D	W	M		D	W	M
ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EGGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BEEF	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COFFEE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CANNED VEGETABLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	POULTRY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TOBACCO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RAW VEGETABLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FISH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ARTIFICIAL SWEETENERS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FRESH FRUIT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SEAFOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SODA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WHOLE GRAINS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	WEIGHT CONTROL PILLS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIET FOOD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DAIRY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ORGANIC FOODS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
REFINED SUGAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FRIED FOODS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DO YOU FAST?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	

DO YOU OR DID YOU WORK WITH ANY CHEMICAL, FUME, DUST, POWDER OR SMOKE FOR PROLONGED PERIODS? YES NO

PLEASE EXPLAIN: _____

AUTHORIZATIONS:

A. I authorize payment of any medical benefit from third-parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office by my attorney out of proceeds of any settlement of my case and by any insurance company contractually obliged to make payment to me or you based upon the charges submitted for products and services rendered.

B. I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for products or professional services rendered will be immediately due and payable.

C. I authorize the doctors and staff of this clinic to examine and treat me as they find necessary. I further authorize clinic personnel to release medical information regarding my care to insurance companies or other professionals if necessary. I certify that all the information I have given is true and correct. I also certify that I am here for the sole purpose of getting better and no other reason.

PATIENT'S SIGNATURE: _____

DATE: _____

GUARDIAN SIGNATURE: _____

DATE: _____

COMPREHENSIVE REVIEW OF SYSTEMS

The PURPOSE of this questionnaire is to comprehensively evaluate each of your body's organ systems over the last SIX MONTHS.

If the symptom or event has not occurred within the last **6 months**, mark **'N'**

If the symptom or event is **Frequent** or **common**, then select **'F'**

If the symptom or event is **Rare** or **uncommon**, then select **'R'**

If the symptom or event is **persistent**, or your answer is **'YES'**, then select **'A'**

N R F A	Consume breads / pastas / starches	N R F A	Can't gain weight	N R F A	Belching
N R F A	Yeast / Fungal problems	N R F A	Slow metabolism	N R F A	Ulcers
N R F A	Tickle in your throat	N R F A	Overweight	N R F A	Pain after eating
N R F A	Cough / spit clear sputum / phlegm	N R F A	Gout	N R F A	Heartburn medication
N R F A	Unexplained weight loss	N R F A	Diabetes	N R F A	Indigestion or bloating
N R F A	Nervousness or irritability	N R F A	Metabolic syndrome	N R F A	Abdominal cramps or pain
N R F A	Thinning of the skin	N R F A	Thyroid problems	N R F A	Irritable Bowel Syndrome
N R F A	Prostate problems	N R F A	Too much stress / tension	N R F A	Diarrhea
N R F A	A family history of diabetes	N R F A	Heat / cold intolerance	N R F A	Inflamed intestine - "Leaky Gut"
N R F A	A family history of cancer	N R F A	Cough/spit green-yellowish sputum	N R F A	Dark black / tarry stools
N R F A	A family history of heart disease	N R F A	Trouble with edema / swelling	N R F A	Blood on the toilet paper
N R F A	Alcohol socially	N R F A	Early aging	N R F A	Chron's Disease
N R F A	Alcohol use extensively	N R F A	Trouble sweating	N R F A	Ulcerative Colitis
N R F A	Do you use street drugs	N R F A	Fatigue or tired	N R F A	Colon polyps
N R F A	Drink coffee / soda / ice tea	N R F A	Unexplained swellings	N R F A	Diverticulitis
N R F A	Smoke or use tobacco	N R F A	Diabetic medications	N R F A	Constipation
N R F A	Eat fast food	N R F A	Thyroid medication	N R F A	Laxitives
N R F A	Eat pre processed / packaged foods	N R F A	Diuretics	N R F A	Urinary tract infections
N R F A	Consume sweets	N R F A	Erectile dysfunction	N R F A	Kidney stones
N R F A	Use artificial sweeteners	N R F A	Pre-menopause	N R F A	Blood in your urine
N R F A	Drink cow's milk	N R F A	Peri-menopause	N R F A	Bed wetting
N R F A	Consume white sugar	N R F A	Suffer from PMS	N R F A	Urinary discharge (abnormal)
N R F A	Consume refined carbs	N R F A	Breast tenderness	N R F A	Dark or smelly urine
N R F A	Consume wheat or gluten	N R F A	Vaginal discharge	N R F A	Over-active bladder
N R F A	Consume artificial flavorings	N R F A	Vaginal dryness	N R F A	Urinary urgency
N R F A	Very little exercise	N R F A	Birth control	N R F A	Urinary hesitancy
N R F A	Family or financial stressors	N R F A	Irregular periods	N R F A	Headaches or migraines
N R F A	Rashes	N R F A	Excessive period bleeding	N R F A	Stiffness or muscle spasms
N R F A	Roseacea	N R F A	Athlete's Foot	N R F A	Bone pains
N R F A	Itchy or dry skin	N R F A	Ovarian cysts	N R F A	Difficulty exercising
N R F A	Oily skin	N R F A	Fibrocystic breasts	N R F A	Fibromyalgia
N R F A	Acne	N R F A	Fertility concerns	N R F A	Chronic fatigue syndrome
N R F A	Eczema	N R F A	Increase in urination	N R F A	Back pain or neck pain
N R F A	Psoriasis	N R F A	Pelvic pain or cramping	N R F A	Joint pain
N R F A	Skin cancer	N R F A	Mood swings	N R F A	Arthritis
N R F A	Vertigo / dizziness	N R F A	Bouts of depression	N R F A	Rheumatoid arthritis
N R F A	Lightheadedness	N R F A	Manic episodes	N R F A	Muscle weakness
N R F A	Glaucoma	N R F A	Loosing your memory	N R F A	Osteoporosis
N R F A	Cataracts	N R F A	Hot flashes / sweats	N R F A	Muscle relaxors
N R F A	Double vision or blurred vision	N R F A	Thinning hair or brittle hair	N R F A	Seizures
N R F A	Dry or red eyes	N R F A	Sexually transmitted disease	N R F A	Anti-depressants
N R F A	Macular degeneration	N R F A	Decrease in sex drive	N R F A	Pain medications
N R F A	Watery eyes	N R F A	Pain with sex	N R F A	Multiple sclerosis
N R F A	Itchy eyes	N R F A	Hormone replacement	N R F A	Numbness or tingling
N R F A	Puffy eyes	N R F A	Heart medication	N R F A	Poor coordination
N R F A	Ear infections	N R F A	A heart attack	N R F A	ADD / ADHD learning disorders
N R F A	Tooth cavities	N R F A	Heart surgery	N R F A	Brain fog - lack of concentration
N R F A	Bad breath	N R F A	Chest pain / angina / tightness	N R F A	Anxiety / anxiousness
N R F A	Runny nose / sneezing	N R F A	High blood pressure	N R F A	Problems relaxing
N R F A	COPD / lung disease	N R F A	A-fib or arrhythmias	N R F A	Feelings of worthlessness
N R F A	Emphysema	N R F A	Heart problems	N R F A	Allergies
N R F A	Chronic bronchitis	N R F A	Slow or fast heart beats at rest	N R F A	Sick more often
N R F A	Difficulty breathing deeply	N R F A	Deep vein thrombosis	N R F A	Swollen glands
N R F A	Acute or chronic coughing	N R F A	Poor circulation in hands	N R F A	Recently taken antibiotics
N R F A	Wheezing with breathing	N R F A	Poor circulation in feet	N R F A	Scleroderma or Sjogrens disease
N R F A	Asthma	N R F A	Concerns about a stroke	N R F A	Fever blisters or cold sores
N R F A	Shortness of breath	N R F A	Restless Leg Syndrome	N R F A	Warts
N R F A	Pain when taking a breath	N R F A	Bruise easily	N R F A	Sore throat
N R F A	Difficulty going to sleep	N R F A	Heart burn or reflux	N R F A	Cholesterol problems
N R F A	Hungry all the time	N R F A	Upset stomach	N R F A	Cholesterol medication
N R F A	Can't lose weight			N R F A	Gall bladder attacks