

Endobiogénie Health History Follow-up Questionnaire

Name: _____ Today's Date: _____ Date of birth: _____

Since your last evaluation, how closely have you been following your Endobiogenic recommendations on the following scale? (you can place an X on the line under the appropriate description)

Not at all ----- **A little** ----- **Fairly well** ----- **Quite well** ----- **Precisely**
 (0% - 10%) (10% - 50%) (50% - 75%) (75% - 90%) (90% - 100%)

- a) Diet: _____
- b) Herbs: _____
- c) Supplements: _____
- d) Exercise: _____
- e) Lifestyle: _____

What additional treatments have you undergone?

- a) Medications: _____
- b) Acupuncture: _____
- c) Massage: _____
- d) Counseling: _____
- e) Other forms of therapy (includes radiation) _____

What additional testing have you had (such as bloodwork, Xrays, CT scans, MRI's)?

- a) Test date: _____ Test: _____ Results: _____
- b) Test date: _____ Test: _____ Results: _____

Since your last evaluation, how do you feel your three main symptoms have been? (if applicable)

Symptom	Much worse ----- Unchanged ----- Much better									
	1	2	3	4	5	6	7	8	9	10
1. _____										
2. _____										
3. _____										

Have you developed any new symptoms or medical problems?

Please list your current medications and herbs (other than your Endobiogenic Treatment):

Name _____ Date _____

Have you had any changes in household, alcohol use, tobacco use, recreational drug use, travel, work, or pets?

What is your current stress level on a scale of 1-10? _____

What is your major source of stress? _____

Review of systems:

Do you sleep well at night? _____ How many hours on average? _____

Do you remember your dreams? _____ Are they in color? _____

Do you hear voices in your dreams? _____

Do you have unusual dreams or nightmares? _____

Do you tend to take a nap during the day? _____

Are your hands and feet generally cold or hot? _____ Moist or dry? _____

Is your appetite generally increased, decreased, or average? _____

Do you tend to eat larger, smaller, or average quantities? _____

Do you prefer salt or sugar? _____

Do you have increased thirst? _____ Excessive saliva? _____

Since your last evaluation, have you been having any of the following?

fatigue		breast pain/discharge		muscle pain		urinary problems
frequent headaches		cough		joint pain		weight gain or loss
neck pain		difficulty breathing		back pain		frequent infections
teeth grinding		abdominal pain		skin color changes		fever, chills, sweats
enlarged tonsils/glands		appetite disturbance		dry skin		easily startled
nasal congestion		nausea		eczema or rashes		easily brought to tears
sore throat		vomiting		acne or boils		anxiety
environmental allergies		excess belching or gas		hair loss		depression
chest pain		diarrhea		brittle nails		sexual dysfunction
heart palpitations		constipation		new moles		memory disturbance
heartburn		hemorrhoids				

(Women only)

(If applicable)

Date of last menstrual period _____

Have you had any changes in your menstrual cycle or flow? _____

Abnormal vaginal discharge? _____

Menopausal symptoms? _____

Completed by: _____ **Date:** _____

Reviewed by: _____ **Date:** _____