

Present: Weight _____ pounds
 Height _____ inches

Patient's Signature _____

Health History

Check only those conditions which are applicable:

- | | | |
|---|---|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Abnormal Weight Gain | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Abnormal Weight Loss | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Fainting | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Allergy Shots | <input type="checkbox"/> Fractures | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Angina | <input type="checkbox"/> General Fatigue | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Gout | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Headache | <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Rapid Heart Beat |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Breast Lumps/Soreness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Systemic Lupus |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tinnitus (Ear Noises) |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irregular Menstrual Flow | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Jaw Pain (TMJ) | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Visual Disturbances |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Liver/Gallbladder Problems | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Loss of Bladder Control | _____ |
| <input type="checkbox"/> Difficulty in Swallowing | <input type="checkbox"/> Measles | _____ |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Migraine Headaches | _____ |

Date of last examination _____ Family Doctor/Specialist _____

List any surgeries that you have had and the dates performed: _____

Hospitalizations: _____

List all medications/supplements that you are currently taking: _____

What type of exercise do you perform? None Moderate Heavy

What do your daily work habits include (ex. Sitting, standing, light labor, heavy labor, computer work)? _____

Please check all that apply: Use Tobacco Drink alcohol Use Caffeine

Has a family member had any of the following: Cancer Diabetes

Rheumatoid Arthritis Heart Problems Lung Problems Epilepsy

High Blood Pressure Back Problems Headaches Other

Doctor's Notes/Additional Comments: _____

