Please check any of the following conditions you currently have or have had in the past.

□ AIDS/ HIV □ Diabetes □ Measles □ Seizures

□ Alcoholism □ Emphysema □ Multiple Sclerosis □ Stroke

□ Allergies □ Epilepsy □ Mumps □ Thyroid Disorders

□ Appendicitis □ Goiter □ Pacemaker □ Tuberculosis

□ Arteriosclerosis □ Gout □ Pleurisy □ Typhoid Fever

□ Asthma □ Heart Disease □ Pneumonia □ Ulcers

□ Birth Trauma □ Hepatitis □ Polio □ Venereal Disease

□ Cancer □ Herpes □ Rheumatic Fever □ Other (specify):

□ Chicken Pox □ High Blood Press. □ Scarlet Fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications:

Medication Name Strength How Many Per Day? For How Long?

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

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

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

Known Allergies:

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

Past Surgeries:

Date Problem

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

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

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

Significant Trauma (ex. auto accidents, falls, injuries)

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

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

Major Medical Conditions in Family History:

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

***Diet/ Lifestyle:***

□ Poor Appetite □ Coffee □ Artificial Sweeteners □ Alcohol

□ High Appetite □ Soft Drinks □ Smoking □ Tobacco

□ Rec. Drugs □ High Stress # Glasses Water Per Day: \_\_\_\_\_\_

­­Typical Diet Includes the Following Foods:

Morning- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Afternoon- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evening- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks- \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vitamins/ Nutritional Supplements Taken Regularly:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you Exercise Regularly? Yes No

Exercise: Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***General Symptoms:***

□ Recent Weight Gain □ Difficulty Getting to Sleep □ Sweat Easily

□ Recent Weight Loss □ Cannot Stay Asleep □ Fatigue/ Tiredness

□ Difficulty losing weight □ Fever □ Dizziness or Vertigo

□ Bruise or Bleed Easily □ Chills □ Cold hands or feet

***Musculoskeletal***

□ Neck Pain □ Muscle Pain □ Joint Pain □ Foot Pain

□ Low Back Pain □ Shoulder Pain □ Nerve Pain □ Other(specify):

□ Upper Back Pain □ Limited Range of Motion □ Knee Pain □ Other(specify):

□ Muscle Cramps □ Body Aches □ Knee Pain □ Other(specify):

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***Head/ Senses***

□ Itchy Eyes □ TMJ □ Dry Mouth □ Sinus Congestion

□ Vision Problems □ Facial Pain □ Mouth Sores □ Runny Nose

□ Glasses □ Teeth Grinding □ Excessive Saliva □ Headaches

□ Sneezing □ Recurring Sore Throat □ Ringing in Ears □ Migraines

□ Excessive Phlegm □ Dental Problems □ Hearing Problems □ Concussion

Color of Phlegm: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Nosebleeds □ Abnormal Mouth Taste

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***Digestive***

□ Acid Reflux □ Frequent Gas □ Vomit □ Abdominal Pain

□ Heartburn □ Bloating □ Hemorrhoids □ Bowel Movements:

□ Nausea □ Diarrhea □ Itchy Anus Frequency: \_\_\_\_\_\_\_\_\_\_\_\_

□ Belching □ Constipation □ Rectal Pain Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Bad Breath □ Mucus in Stools □ Blood in Stools (loose, hard, intermediate)

□ Crave Sweets □ Tired After Meals □ Lightheaded/ Shaky if meals are missed

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***Respiratory***

□ Pneumonia □ Asthma □ Cough: Wet or Dry? \_\_\_\_\_\_\_\_\_\_

□ Bronchitis □ Shortness of Breath □ Chest Tightness Color of Phlegm: \_\_\_\_\_\_\_

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***Cardiovascular***

□ High Blood Pressure □ Blood Clots □ Palpitations □ Difficult Breathing

□ Low Blood Pressure □ Chest Pain □ Irregular Heartbeat □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Neuropsychological***

□ Numbness □ Depression □ Emotional Trauma □ Considered Suicide

□ Seizures □ Anxiety □ Seeing a Therapist □ Other (specify):

□ Tics □ Stress Easily □ Poor Memory \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Skin & Hair***

□ Rash □ Eczema □ Excess Hair Loss □ Dandruff

□ Itching □ Psoriasis □ Dry Skin □ Early Hair Greying

□ Acne □ Dandruff □ Fungal Infection □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Genitourinary***

□ Pain on Urination □ Incontinence □ High Libido □ Impotence

□ Frequent Urination □ Bedwetting □ Low Libido □ Premature Ejaculation

□ Urgent Urination □ Dandruff □ Kidney Stones □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***Gynecological***

□ Irregular Periods □ Clots Length of Cycle: \_\_\_\_\_\_\_\_\_\_ # Pregnancies: \_\_\_\_\_\_\_\_\_

□ Painful Periods □ PMS Duration of Flow: \_\_\_\_\_\_\_\_\_ # Live Births: \_\_\_\_\_\_\_\_\_\_

□ Vaginal Discharge □ Breast Pain Date of Last Period: \_\_\_\_\_\_\_ # Premature Births: \_\_\_\_\_\_

Discharge Color: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at Menopause: \_\_\_\_\_\_\_\_