Please check **(Y)** if you currently have the condition. Check **(N)** if you do not currently have this condition.

GENERAL

1 ☐Y ☐N **Fever**
2 ☐Y ☐N **Chills**
3 ☐Y ☐N **Night Sweats**
4 ☐Y ☐N **Loss of Sleep**
5 ☐Y ☐N **Fatigue**
6 ☐Y ☐N **Nervousness**
7 ☐Y ☐N **Weight Loss/Gain**
8 ☐Y ☐N **Allergies**
☐Environmental
☐Food
9 ☐Y ☐N **Bleeding Problem**
10 ☐Y ☐N **Anemia**
11 ☐Y ☐N **Diabetes**
☐I am currently taking insulin
12 ☐Y ☐N **Cancer**
Type _______________
13 ☐Y ☐N **Thyroid Disease/Goiter**
14 ☐Y ☐N **Alcoholism**
15 ☐Y ☐N **Drug Abuse**

Medications taking for these conditions:

____

EYE EAR NOSE THROAT

16 ☐Y ☐N **Change of Vision**
☐ Reading ☐ Driving
17 ☐Y ☐N **Pain in Eye(s)**
18 ☐Y ☐N **Deafness/Difficulty Hearing/ Ear Noises**
19 ☐Y ☐N **Nosebleeds**
20 ☐Y ☐N **Nose Problems**
21 ☐Y ☐N **Sinus Trouble**
22 ☐Y ☐N **Dental Problems**
23 ☐Y ☐N **Hoarseness**
24 ☐Y ☐N **Tonsillectomy/Date___/___/___**

Medications Taking for Eye Ear Nose Throat conditions:

____

GASTROINTESTINAL

25 ☐Y ☐N **Change of Appetite**
26 ☐Y ☐N **Poor Digestion**
27 ☐Y ☐N **Difficulty Swallowing**
28 ☐Y ☐N **Belching/Gas**
29 ☐Y ☐N **Nausea**
30 ☐Y ☐N **Vomiting**
31 ☐Y ☐N **Vomiting Blood**
32 ☐Y ☐N **Pain over Abdomen**
33 ☐Y ☐N **Ulcer**
34 ☐Y ☐N **Black or Bloody Stools**
35 ☐Y ☐N **Liver Problems**
36 ☐Y ☐N **Gall Bladder Problems**
37 ☐Y ☐N **Jaundice**
38 ☐Y ☐N **Hernia**
39 ☐Y ☐N **Diarrhea**
40 ☐Y ☐N **Constipation**
41 ☐Y ☐N **Hemorrhoids**
42 ☐Y ☐N **Appendicitis/ Date___/___/___**

Medications taking for Gastrointestinal conditions:

____

RESPIRATORY

43 ☐Y ☐N **Difficulty Breathing**
44 ☐Y ☐N **Chronic Cough**
45 ☐Y ☐N **Spitting Phlegm**
46 ☐Y ☐N **Spitting Blood**
47 ☐Y ☐N **Wheezing Asthma**
48 ☐Y ☐N **Pneumonia/ Date___/___/___**
49 ☐Y ☐N **Tuberculosis**

Medications taking for Respiratory conditions:

____

CARDIOVASCULAR

50 ☐Y ☐N **Irregular Heartbeat**
51 ☐Y ☐N **High Blood Pressure**
Last Reading ____/____
52 ☐Y ☐N **Pain Over Heart**
53 ☐Y ☐N **Previous Heart Trouble**
54 ☐Y ☐N **Ankle Swelling**
55 ☐Y ☐N **Varicose Veins**
56 ☐Y ☐N **Rheumatic Fever**
57 ☐Y ☐N **Stroke/Date___/___/___**

Medications taking for Cardiovascular conditions:

____

____

GENITOURINARY

58 ☐Y ☐N **Frequent Urination**
69 ☐Y ☐N **Painful Urination**
60 ☐Y ☐N **Blood in Urine**
61 ☐Y ☐N **Kidney Disease**
62 ☐Y ☐N **Current Urinary Infection**
63 ☐Y ☐N **Inability Control Urination**
64 ☐Y ☐N **Difficulty Start Urine Flow**
65 ☐Y ☐N **Urinate___Times per Night**
66 ☐Y ☐N **Breast Lump or Pain**
67 ☐Y ☐N **Sexual Difficulties**

Medications taking for Genitourinarial conditions:

____

SKIN

68 ☐Y ☐N **Itching**
69 ☐Y ☐N **Bruising Easily**
70 ☐Y ☐N **Change in Mole(s)**
71 ☐Y ☐N **Skin Cancer**
Type__________________
Date Removed___/___/___

Medications taking for skin conditions:

____

WOMEN ONLY

72 ☐Y ☐N **Painful Periods**
73 ☐Y ☐N **Excessive Flow**
74 ☐Y ☐N **Irregular Cycles**
75 ☐Y ☐N **Vaginal Burning/Itching**
76 ☐Y ☐N **Hot Flashes**
77 **Date Last Period Began________**
78 **Date of Last PAP Test__________**

Medications taking for these conditions:

____

NEUROLOGIC

79 ☐Y ☐N **Weakness**
80 ☐Y ☐N **Twitching**
81 ☐Y ☐N **Tremors**
82 ☐Y ☐N **Headaches**
83 ☐Y ☐N **Fainting**
84 ☐Y ☐N **Dizziness**
85 ☐Y ☐N **Convulsions**
86 ☐Y ☐N **Epilepsy**
87 ☐Y ☐N **Numbness/Tingling**
88 ☐Y ☐N **Arm/Leg Pain**
89 ☐Y ☐N **Forgetfulness/Confusion/ Depression**

Medications taking for Neurological conditions:

____

MUSCULOSKELETAL

90 ☐Y ☐N **Neck Stiffness/Pain**
91 ☐Y ☐N **Pain Between Shoulders**
92 ☐Y ☐N **Low Back Pain**
93 ☐Y ☐N **Swollen Joints**
94 ☐Y ☐N **Painful Joints**
95 ☐Y ☐N **Muscle Aches/Soreness**
96 ☐Y ☐N **Spinal Curvature**
97 ☐Y ☐N **Arthritis**

Medications taking for Musculoskeletal conditions:

____

MEN ONLY

98 ☐Y ☐N **Testicular Swelling/Pain**
99 ☐Y ☐N **Prostate Problems**

Medications taking for these conditions:

____

HABITS

100 ☐Y ☐N **Smoking**
____Pack per Day
____Years Smoking
101 ☐Y ☐N **Drinking Alcohol**
☐ Light ☐ Moderate ☐ Heavy
102 **I drink ___ glasses of water a day**

DIET

103 (Check one)

☐ **I frequently eat fast foods (more than 6 times/month), soft drinks, candy, etc.**

☐ **I occasionally eat fast foods (1-5 times/month), soft drinks, candy, etc.**

☐ **It is extremely rare for me to eat fast foods, soft drinks, candy, etc. I typically eat 5 servings of fruit & vegetables per day.**

EXERCISE

104 ☐ **None** ☐ **3-5 Weekly**
☐ **1-2 Weekly** ☐ **6-7 Weekly**

COMMON SLEEPING POSTION

Please check all that apply.

105 ☐ **Back** ☐ **Side** ☐ **Stomach**

III FAMILY HISTORY (Grandparents, Parents, Brothers, Sisters, Children)

	Your Family	Relationship
B. Heart Disease	☐Yes ☐No	____________
C. Cancer	☐Yes ☐No	____________
D. Stroke	☐Yes ☐No	____________
E. Diabetes	☐Yes ☐No	____________
F. Arthritis	☐Yes ☐No	____________
F. High Blood Pressure	☐Yes ☐No	____________
G. Kidney Disease	☐Yes ☐No	____________
H. Muscle/Bone/Nerve Disease	☐Yes ☐No	____________
I. Thyroid Disease	☐Yes ☐No	____________
J. Other		____________