

**7.CONDITIONS** *Mark conditions that you are having or have had within the last year.*

- |                                   |                        |                         |                         |
|-----------------------------------|------------------------|-------------------------|-------------------------|
| € Low Back Pain                   | € Headaches            | € Nervous               | € Stroke                |
| € Pain Between Shoulders          | € Chills               | € Numbness              | € Ringing in Ears       |
| € Neck Pain                       | € Depression/Confusion | € Paralysis             | € Sinus Problems        |
| € Arm Pain                        | € Dizziness            | € Convulsions           | € Flashes               |
| € Shoulder Pain                   | € Fainting             | € Cold Hands and Feet   | € Halos                 |
| € Leg Pain                        | € Chest Pain           | € High Blood Pressure   | € Bruise Easily         |
| € Hip Pain                        | € Irregular Heart Beat | € Low Blood Pressure    | € Hives                 |
| € Joint Pain/Stiffness            | € Poor Circulation     | € Swelling of Ankles    | € Itching               |
| € Walking Problems                | € Fever                | € Tingling Extremities  | € Change in Moles       |
| € Difficulty Chewing/Clicking Jaw | € Forgetfulness        | € Stress                | € Rash                  |
| € General Stiffness               | € Loss of Weight       | € Blurred Vision        | € Sores that won't heal |
| € Gas/Bloating                    | € Loss of Sleep        | € Crossed Eyes          | € Bleeding Gums         |
| € Heartburn                       | € Nausea               | € Difficulty Swallowing | € Nose Bleeds           |
| € Bloody Stool                    | € Vomiting             | € Earache               | € Persistent Cough      |
| € Diarrhea                        | € Painful Urination    | € Ear Discharge         | € Loss of Hearing       |
| € Constipation                    | € Bladder Trouble      | € Hay Fever             | € Hoarseness            |
| € Excessive Hunger                | € Excessive Thirst     | € Hemorrhoids           | € Colitis               |

**MEN ONLY**

- € Breast Lump
- € Prostate Dysfunction
- € Sexual Dysfunction
- € Lump in Testicles
- € Surgical Implants
- € Other

**WOMEN ONLY**

- Are You Pregnant €Y €N
- € Date of Last Period \_\_\_\_\_
- € Abnormal Pap Smear
- € Bleeding between Periods
- € Breast Lump
- € Extreme Menstrual Pain
- € Hot Flashes
- € Nipple Discharge
- € Vaginal Discharge
- € Surgical Implants

**8.DISEASES** *Mark conditions you have or have had in the past.*

- |                      |                       |                    |                      |                      |
|----------------------|-----------------------|--------------------|----------------------|----------------------|
| € AIDS               | € Cancer              | € Gout             | € Migraine Headache  | € Stroke             |
| € Alcoholism         | € Cataracts           | € Heart Disease    | € Mononucleosis      | € Suicide Attempt    |
| € Anemia             | € Chemical Dependency | € Hepatitis        | € Multiple Sclerosis | € Thyroid Problem    |
| € Anorexia           | € Chicken Pox         | € Hernia           | € Mumps              | € Tonsillitis        |
| € Appendicitis       | € Diabetes            | € Herpes           | € Pacemaker          | € Tuberculosis       |
| € Arthritis          | € Emphysema           | € High Cholesterol | € Pneumonia          | € Typhoid Fever      |
| € Asthma             | € Epilepsy            | € HIV Positive     | € Polio              | € Ulcers             |
| € Bleeding Disorders | € Glaucoma            | € Kidney Disease   | € Psychiatric Care   | € Vaginal Infections |
| € Bronchitis         | € Goiter              | € Liver Disease    | € Rheumatic Fever    | € Venereal Disease   |
| € Bulimia            | € Gonorrhea           | € Measles          | € Scarlet Fever      | € Other              |

**9.MEDICATIONS** *List medications you are currently taking.*

Medicine Name	Frequency	Purpose
1		
2		
3		
4		
Pharmacy Name	Phone #	

**10.SURGERIES /HOSPITALIZATIONS** *List all accidents too*

Reason For Hospitalization	Year	Outcome
Please list all Broken bones:		

**11.FAMILY HEALTH HISTORY** *Please fill the following section very carefully as many problems are hereditary.*

Please List Age	Arthritis	Asthma	Back/Neck pain	Cancer	Diabetes	Disc Prob.	Headaches	Heart Disease	High BP	High Chol.	Kidney	Liver	Scoliosis	Other (list)
Father( )														
Mother( )														
Spouse( )														
Brothers( )														
Sisters( )														
Son ( )														
Son ( )														
Daughter( )														
Daughter( )														

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of the staff responsible for any omissions that I may have made in the completion of this form.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Reviewed By \_\_\_\_\_