

OTHER ILLNESSES OR CONDITIONS:

Are you being treated for any other illnesses or conditions at the present time? Yes No If Yes, please list below:

Illness/Condition	Provider	Address (City/County)	Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICAL HISTORY (check all that apply):

- | | | | |
|--|---|--|---|
| Polio <input type="checkbox"/> | Glaucoma <input type="checkbox"/> | Stroke <input type="checkbox"/> | Back Problems <input type="checkbox"/> |
| Scarlet Fever <input type="checkbox"/> | Venereal Disease <input type="checkbox"/> | Kidney Disease <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> |
| Pneumonia <input type="checkbox"/> | Anemia <input type="checkbox"/> | Blood/Plasma Transfusions <input type="checkbox"/> | Heart Disease <input type="checkbox"/> |
| Emphysema <input type="checkbox"/> | Bladder Infections <input type="checkbox"/> | Hemorrhoids <input type="checkbox"/> | Heart Attack <input type="checkbox"/> |
| Thyroid Disease <input type="checkbox"/> | Epilepsy <input type="checkbox"/> | Hearing Loss <input type="checkbox"/> | Heart Failure <input type="checkbox"/> |
| Hepatitis <input type="checkbox"/> | Arthritis <input type="checkbox"/> | AIDS/HIV+ <input type="checkbox"/> | Bleeding/Blood Disease <input type="checkbox"/> |
| Rheumatic Fever <input type="checkbox"/> | Bronchitis <input type="checkbox"/> | Migraine Headaches <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Asthma <input type="checkbox"/> | Ulcers <input type="checkbox"/> | Hernia <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | If checked, what type of cancer: _____ | | |

Other Diseases? _____

PATIENT SOCIAL HISTORY:

- Marital Status: Single Married Separated Divorced Widowed
- Alcohol Use: Never Rarely Moderately Daily - Quantity: _____
- Tobacco Use: Never Did smoke but stopped Smoker - Quantity: _____
- Drug Use: Never Yes

Excessive Exposure at Home or Work (Check all that apply) Fumes Solvents Dust Airborne Particles

FAMILY MEDICAL HISTORY:

Relationship	Age	Diseases	If deceased, cause of death
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PREVIOUS HOSPITALIZATIONS, SURGERIES AND/OR SERIOUS ILLNESSES:

Are you being treated for any other illnesses or conditions at the present time? Yes No If Yes, please list below:

Hospital, City and State	Begin Date	End Date	Type Surgery/Illness
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS:

CURRENT MEDICATIONS: *(Include nonprescription/over-the-counter medications)*

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

MEDICATION ALLERGIES: *(Please list below)*

CONSTITUTIONAL SYMPTOMS:

GENERAL

- Good general health lately Yes No
- Recent weight change Yes No
- Fever Yes No
- Fatigue Yes No
- Headaches Yes No

EYES

- Eye disease or Injury Yes No
- Wear glasses/contact lenses Yes No
- Blurred or double vision Yes No

EAR/NOSE/MOUTH/THROAT

- Hearing loss or ringing Yes No
- Earaches or drainage Yes No
- Chronic sinus problems or rhinitis Yes No
- Nose bleeds Yes No
- Mouth sores Yes No
- Bleeding gums Yes No
- Bad breath or taste Yes No
- Sore throat or voice change Yes No
- Swollen glands in neck Yes No
- Vision loss Yes No
- Speech problems Yes No

CARDIOVASCULAR:

- Heart trouble Yes No
- Chest pain or angina pectoris Yes No
- Palpitations Yes No

- Shortness of breath walking or lying flat Yes No
- Swelling of feet, ankles or hands Yes No

RESPIRATORY:

- Chronic or frequent cough Yes No
- Spitting up of blood Yes No

- Shortness of breath Yes No
- Wheezing Yes No

GASTROINTESTINAL:

- Loss of appetite Yes No
- Painful bowel movements Yes No
- Constipation Yes No
- Rectal Bleeding or blood in stool Yes No

- Abdominal pain Yes No
- Change in bowel movement Yes No
- Nausea or vomiting Yes No
- Frequent diarrhea Yes No

GENITOURINARY:

- Frequent urination Yes No
- Burning or painful urination Yes No
- Blood in urine Yes No
- Change in force of strain when urinating Yes No
- Incontinence or dribbling Yes No
- Kidney stones Yes No
- Sexual difficulty Yes No

- Male – Testicle Pain Yes No
- Female – irregular periods Yes No
- Female – pain with periods Yes No
- Female – vaginal discharge Yes No
- Female – # of pregnancies _____
- Female – # of miscarriages _____

MUSCULOSKELETAL:

- | | | | | | |
|--------------------------|---------------------------|--------------------------|-----------------------|---------------------------|--------------------------|
| Joint pain | <input type="radio"/> Yes | <input type="radio"/> No | Back pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Joint stiffness/swelling | <input type="radio"/> Yes | <input type="radio"/> No | Neck pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Weakness – muscles | <input type="radio"/> Yes | <input type="radio"/> No | Cold extremities | <input type="radio"/> Yes | <input type="radio"/> No |
| Muscle pain or cramps | <input type="radio"/> Yes | <input type="radio"/> No | Difficulty in walking | <input type="radio"/> Yes | <input type="radio"/> No |

INTEGUMENTARY:

- | | | | | | |
|----------------------|---------------------------|--------------------------|------------------|---------------------------|--------------------------|
| Rash or itching | <input type="radio"/> Yes | <input type="radio"/> No | Breast pain | <input type="radio"/> Yes | <input type="radio"/> No |
| Change in skin color | <input type="radio"/> Yes | <input type="radio"/> No | Breast lump | <input type="radio"/> Yes | <input type="radio"/> No |
| Varicose veins | <input type="radio"/> Yes | <input type="radio"/> No | Breast discharge | <input type="radio"/> Yes | <input type="radio"/> No |

NEUROLOGICAL:

- | | | | | | |
|-------------------------|---------------------------|--------------------------|-------------|---------------------------|--------------------------|
| Frequent headaches | <input type="radio"/> Yes | <input type="radio"/> No | Tremors | <input type="radio"/> Yes | <input type="radio"/> No |
| Light headed or dizzy | <input type="radio"/> Yes | <input type="radio"/> No | Paralysis | <input type="radio"/> Yes | <input type="radio"/> No |
| Convulsions or seizures | <input type="radio"/> Yes | <input type="radio"/> No | Head Injury | <input type="radio"/> Yes | <input type="radio"/> No |
| Numbness or tingling | <input type="radio"/> Yes | <input type="radio"/> No | | | |

PSYCHIATRIC:

- | | | | | | |
|--------------------------|---------------------------|--------------------------|------------|---------------------------|--------------------------|
| Memory loss or confusion | <input type="radio"/> Yes | <input type="radio"/> No | Depression | <input type="radio"/> Yes | <input type="radio"/> No |
| Nervousness | <input type="radio"/> Yes | <input type="radio"/> No | Insomnia | <input type="radio"/> Yes | <input type="radio"/> No |

ENDOCRINE:

- | | | | | | |
|-------------------------------|---------------------------|--------------------------|-----------------------------|---------------------------|--------------------------|
| Glandular or hormone problem | <input type="radio"/> Yes | <input type="radio"/> No | Skin becoming drier | <input type="radio"/> Yes | <input type="radio"/> No |
| Excessive thirst or urination | <input type="radio"/> Yes | <input type="radio"/> No | Change in hat or glove size | <input type="radio"/> Yes | <input type="radio"/> No |
| Heat or cold intolerance | <input type="radio"/> Yes | <input type="radio"/> No | | | |

HEMATOLOGIC/LYMPHATIC:

- | | | | | | |
|--|---------------------------|--------------------------|------------------------|---------------------------|--------------------------|
| History of skin reaction or other adverse affect | <input type="radio"/> Yes | <input type="radio"/> No | Phlebitis | <input type="radio"/> Yes | <input type="radio"/> No |
| Bleeding or bruising tendency | <input type="radio"/> Yes | <input type="radio"/> No | Past blood transfusion | <input type="radio"/> Yes | <input type="radio"/> No |
| Anemia | <input type="radio"/> Yes | <input type="radio"/> No | Enlarged glands | <input type="radio"/> Yes | <input type="radio"/> No |

ALLERGIC/IMMUNOLOGIC:

Known food allergies:

Known environmental allergies
