





## Health History

Do you have, or have you had, any of the following (*please check ☑ all that apply*)

- |                                 |                               |                                  |                                       |                                |
|---------------------------------|-------------------------------|----------------------------------|---------------------------------------|--------------------------------|
| <input type="radio"/> pneumonia | <input type="radio"/> mumps   | <input type="radio"/> influenza  | <input type="radio"/> rheumatic fever | <input type="radio"/> smallpox |
| <input type="radio"/> pleurisy  | <input type="radio"/> polio   | <input type="radio"/> chickenpox | <input type="radio"/> thyroid disease | <input type="radio"/> diabetes |
| <input type="radio"/> epilepsy  | <input type="radio"/> cancer  | <input type="radio"/> depression | <input type="radio"/> whooping cough  | <input type="radio"/> anemia   |
| <input type="radio"/> eczema    | <input type="radio"/> measles | <input type="radio"/> arthritis  | <input type="radio"/> heart disease   | <input type="radio"/> rashes   |

If you have ever been diagnosed with another disease or condition, please describe \_\_\_\_\_

- Do you use
- |                               |                                  |   |                             |
|-------------------------------|----------------------------------|---|-----------------------------|
| <input type="radio"/> coffee  | <input type="radio"/> tea        | <input type="radio"/> artificial sweeteners | <input type="radio"/> sugar |
| <input type="radio"/> alcohol | <input type="radio"/> cigarettes | <input type="radio"/> recreational drugs    |                             |

Have you ever suffered from (*please check ☑ all that apply*)

- |   |   |  |
|---|---|--|
| <input type="radio"/> neck pain               | <input type="radio"/> stuffy nose         | <input type="radio"/> discolored urine         |
| <input type="radio"/> low back pain           | <input type="radio"/> allergies           | <input type="radio"/> gas/bloating after meals |
| <input type="radio"/> headache                | <input type="radio"/> fainting            | <input type="radio"/> heartburn                |
| <input type="radio"/> migraines               | <input type="radio"/> weight loss         | <input type="radio"/> colitis                  |
| <input type="radio"/> arm back/tingling       | <input type="radio"/> poor appetite       | <input type="radio"/> irritable bowel          |
| <input type="radio"/> shoulder pain           | <input type="radio"/> excessive appetite  | <input type="radio"/> black or bloody stools   |
| <input type="radio"/> hand pain/tingling      | <input type="radio"/> nervousness         | <input type="radio"/> constipation             |
| <input type="radio"/> leg pain/tingling       | <input type="radio"/> confusion           | <input type="radio"/> hemorrhoids              |
| <input type="radio"/> jaw pain                | <input type="radio"/> depression          | <input type="radio"/> liver problems           |
| <input type="radio"/> chest pain              | <input type="radio"/> dental problems     | <input type="radio"/> stroke                   |
| <input type="radio"/> lung problems           | <input type="radio"/> excessive thirst    | <input type="radio"/> paralysis                |
| <input type="radio"/> heart problems          | <input type="radio"/> frequent nausea     | <input type="radio"/> tingling                 |
| <input type="radio"/> abnormal blood pressure | <input type="radio"/> vomiting            | <input type="radio"/> numbness                 |
| <input type="radio"/> irregular heartbeat     | <input type="radio"/> prostate problem    | <input type="radio"/> fatigue                  |
| <input type="radio"/> ankle swelling          | <input type="radio"/> breast pain/lump    | <input type="radio"/> dizziness                |
| <input type="radio"/> cold extremities        | <input type="radio"/> cramps              | <input type="radio"/> loss of sleep            |
| <input type="radio"/> blurred vision          | <input type="radio"/> painful urination   | <input type="radio"/> difficulty hearing       |
| <input type="radio"/> vision problems         | <input type="radio"/> bladder trouble     | <input type="radio"/> ear pain                 |
| <input type="radio"/> difficulty breathing    | <input type="radio"/> excessive urination |  |

If applicable, date of last menstrual period \_\_\_\_\_

Past injuries can affect present health (*please check ☑ all that apply*)

- |   |   |   |
|---|---|---|
| <input type="radio"/> falls/accidents         | <input type="radio"/> head injuries         | <input type="radio"/> fights            |
| <input type="radio"/> sports injuries         | <input type="radio"/> broken bones          | <input type="radio"/> dislocations      |
| <input type="radio"/> spinal tap              | <input type="radio"/> surgery               | <input type="radio"/> traction          |
| <input type="radio"/> use(d) a cane or walker | <input type="radio"/> extensive dental work | <input type="radio"/> dental appliances |
| <input type="radio"/> knocked unconscious     |   |   |

If yes to any of the above, please describe \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

