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**MEDICAL HISTORY**

*Please check the appropriate symptoms or conditions that you are experiencing now*

**GENERAL**

□ Allergies

□ Weight loss

□ Weight Gain

□ Skin irritation

□ Sweats

□ Tremors

□ Chills

□ Fever

**NEUROLOGICAL**

□ Convulsions

□ Dizziness

□ Nausea

□ Numbness

□ Tingling/Burning

□ Nervousness

□ Depression

□ Headaches

□ Muscle weakness

**MUSCLE & JOINT**

□ Shoulder

□ Mid-back pain/stiffness

□ Knee

□ Hip

□ Elbow

□ Neck pain/stiffness

□ Ankle/Foot

□ Spinal curvature

□ Hand/wrist

□ Low-back pain/stiffness

**GENITO-URINARY**

□ Kidney stones

□ Urinary tract infections

□ Painful urination

□ Frequent urination

□ Inability to control urination

**GASTROINTESTINAL**

□ Gall bladder

□ Liver trouble

□ Vomiting blood

□ Hernia

□ Blood in stool

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**RESPIRATORY**

□ Chest pain

□ Difficulty breathing

□ Spitting up blood

□ Asthma

□ Coughing

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**CARDIOVASCULAR**

□ Hardening of arteries

□ Poor circulation

□ High blood pressure

□ Cold extremities

□ Swelling of ankles

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**EYES, EARS, NOSE & THROAT**

□ Enlarged glands

□ Deafness/Loss of hearing

□ Enlarged thyroid

□ Trouble speaking

□ Difficulty swallowing

□ Poor balance

□ Blurred vision

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**FOR WOMEN ONLY**

□ Hot flashes

□ Irregular menstrual cycle

□ Menopausal symptoms

□ Lumps in breasts

□ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Are you pregnant?

□ Yes □ No

If yes, are you breastfeeding?

□ Yes □ No

**OTHER** (specify any additional or unmentioned symptoms/conditions)

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

*Please circle any of the following conditions you presently have or have had in the past*

ALCOHOLISM EMPHYSEMA RHEUMATIC FEVER CANCER TUBERCULOSIS

PNEUMONIA ULCERS POLIO ANEMIA OTHER - specify

STROKE ARTERIOSCLEROSIS GOUT EPILEPSY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEART DISEASE OSTEOPOROSIS ARTHRITIS DIABETES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**