

Past Medical History – Do you have or have had any of these illnesses?

- | | | |
|---|--|--|
| <input type="checkbox"/> 1 Glaucoma or Cataracts | <input type="checkbox"/> 18 Diverticulosis or Diverticulitis | <input type="checkbox"/> 35 Gout |
| <input type="checkbox"/> 2 Macular degeneration | <input type="checkbox"/> 19 Hemorrhoids | <input type="checkbox"/> 36 Rheumatoid Arthritis |
| <input type="checkbox"/> 3 Frequent ear Infection | <input type="checkbox"/> 20 Gall Bladder Disease | <input type="checkbox"/> 37 Osteoarthritis |
| <input type="checkbox"/> 4 Hay fever? Sinus allergies | <input type="checkbox"/> 21 Colitis | <input type="checkbox"/> 38 Lupus |
| <input type="checkbox"/> 5 Chronic sinusitis | <input type="checkbox"/> 22 Frequent Urine infections | <input type="checkbox"/> 39 Psoriasis or Eczema |
| <input type="checkbox"/> 6 Asthma or Emphysema (COPD) | <input type="checkbox"/> 23 Kidney Stone | <input type="checkbox"/> 40 Anxiety or Depression |
| <input type="checkbox"/> 7 Chronic bronchitis | <input type="checkbox"/> 24 Enlarged Prostate | <input type="checkbox"/> 41 Schizophrenia |
| <input type="checkbox"/> 8 Pneumonia | <input type="checkbox"/> 25 Chronic Kidney Disease | <input type="checkbox"/> 42 Bipolar disorder |
| <input type="checkbox"/> 9 Heart Murmur | <input type="checkbox"/> 26 Sexually Transmitted Disease | <input type="checkbox"/> 43 German Measles/Rubella |
| <input type="checkbox"/> 10 High Blood Pressure | <input type="checkbox"/> 27 Diabetes or Pre-Disease | <input type="checkbox"/> 44 Chicken Pox |
| <input type="checkbox"/> 11 Heart attack or heart disease | <input type="checkbox"/> 28 Thyroid disease | <input type="checkbox"/> 45 Measles |
| <input type="checkbox"/> 12 Irregular heartbeat / Pacemaker | <input type="checkbox"/> 29 Varicose Veins/Phlebitis | <input type="checkbox"/> 46 Scarlet Fever |
| <input type="checkbox"/> 13 High cholesterol | <input type="checkbox"/> 30 Tuberculosis | <input type="checkbox"/> 47 Mumps |
| <input type="checkbox"/> 14 Acid Reflux or GERD | <input type="checkbox"/> 31 Stroke | <input type="checkbox"/> 48 Polio |
| <input type="checkbox"/> 15 Hepatitis | <input type="checkbox"/> 32 Epilepsy | <input type="checkbox"/> 49 Rheumatic fever |
| <input type="checkbox"/> 16 Peptic or Stomach Ulcers | <input type="checkbox"/> 33 Migraine headaches | <input type="checkbox"/> 50 Cancer |
| <input type="checkbox"/> 17 Irritable Bowel Syndrome (IBS) | <input type="checkbox"/> 34 Anemia | <input type="checkbox"/> 51 Other _____ |

Review of Symptoms –Do you HAVE or RECENTLY has any of these symptoms?

- | | | |
|--|--|---|
| <input type="checkbox"/> 1 Unusual fatigue or weakness | <input type="checkbox"/> 20 Palpitations or tachycardia | <input type="checkbox"/> 39 Urethral Discharge |
| <input type="checkbox"/> 2 Fever or chills | <input type="checkbox"/> 21 Swelling of feet or legs | <input type="checkbox"/> 40 Bruise or bleed easily |
| <input type="checkbox"/> 3 Recent weight loss or gain | <input type="checkbox"/> 22 Fainting spells | <input type="checkbox"/> 41 Convulsions/Seizures |
| <input type="checkbox"/> 4 decreased hearing | <input type="checkbox"/> 23 leg pain when walking | <input type="checkbox"/> 42 Tremor/hands shaking |
| <input type="checkbox"/> 5 Ringing in ear | <input type="checkbox"/> 24 Loss of appetite | <input type="checkbox"/> 43 Numbness/Tingling Sensation |
| <input type="checkbox"/> 6 Dizzy Spells | <input type="checkbox"/> 25 Difficulty swallowing | <input type="checkbox"/> 44 Frequent headaches |
| <input type="checkbox"/> 7 Earache | <input type="checkbox"/> 26 Indigestion / Heartburn | <input type="checkbox"/> 45 Memory loss |
| <input type="checkbox"/> 8 Failing Vision | <input type="checkbox"/> 27 Persistent nausea / Vomiting | <input type="checkbox"/> 46 Muscle weakness |
| <input type="checkbox"/> 9 Double or Blurred Vision | <input type="checkbox"/> 28 Abdominal pain | <input type="checkbox"/> 47 Back Pain - Recurrent |
| <input type="checkbox"/> 10 Eye pain | <input type="checkbox"/> 29 Change in bowel habits | <input type="checkbox"/> 48 Bone Fracture/Joint Injury |
| <input type="checkbox"/> 11 Eye Infection | <input type="checkbox"/> 30 Diarrhea or Constipation | <input type="checkbox"/> 49 Joint Pain |
| <input type="checkbox"/> 12 Nose Bleeds | <input type="checkbox"/> 31 Bloody or Tarry Stools | <input type="checkbox"/> 50 Cold hands or feet |
| <input type="checkbox"/> 13 Sinus congestion or pain | <input type="checkbox"/> 32 Jaundice (Yellowing of skin) | <input type="checkbox"/> 51 Rashes or itching |
| <input type="checkbox"/> 14 Sore Throat | <input type="checkbox"/> 33 Hernia | <input type="checkbox"/> 52 Hives |
| <input type="checkbox"/> 15 Hoarseness | <input type="checkbox"/> 34 Painful urination | <input type="checkbox"/> 53 Moodiness - Excessive |
| <input type="checkbox"/> 16 Wheezing | <input type="checkbox"/> 35 Blood in urine | <input type="checkbox"/> 54 Nervousness |
| <input type="checkbox"/> 17 Shortness of breath | <input type="checkbox"/> 36 Overnight urination – more than 2 | <input type="checkbox"/> 55 Depression |
| <input type="checkbox"/> 18 Chronic cough | <input type="checkbox"/> 37 Incontinence or dribbling of urine | <input type="checkbox"/> 56 Phobias |
| <input type="checkbox"/> 19 Chest Pain or tightness | <input type="checkbox"/> 38 Decrease in force or urination | <input type="checkbox"/> 57 Other _____ |

Do you wear or use? Eyeglasses or contact lenses Dentures Hearing aides

| | | | | | |
|-------------------------|-----|----|-----------------------|----------------|-----------------|
| Do you wear seat belts? | Yes | No | Do you drink alcohol? | Yes | No |
| | | | Type _____ | How many _____ | How often _____ |

| | | | | | |
|--------------------------------------|-----|----|--|-----|----|
| Do you drink beverages with caffeine | Yes | No | Do you use drugs? (Marijuana, Cocaine, Crack Etc...) | Yes | No |
|--------------------------------------|-----|----|--|-----|----|

Do you smoke cigarettes? Yes No Quit Packs per day _____ How long _____

Name _____ D.O.B _____ Date _____