GENERAL
___ Fever
___ Chills
___ Night Sweats
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Weight Loss or Gain
___ Bleeding Problem
___ Anemia
___ Diabetes
___ Cancer
___ Thyroid Disease/Goiter
___ Alcoholism
___ Drug Abuse

EYE EAR NOSE THROAT
___ Poor vision
___ Pain in Eye(s)
___ Deafness/Difficulty Hearing
___ Nosebleeds
___ Nose Problems
___ Sinus Trouble
___ Dental Problems
___ Hoarseness
___ Tonsillectomy

GASTROINTESTINAL
___ Poor Appetite
___ Poor Digestion
___ Difficulty Swallowing
___ Belching or Gas
___ Frequent Nausea
___ Vomiting
___ Vomiting Blood
___ Pain over Abdomen
___ Ulcer
___ Black or Bloody Stools
___ Liver Problems
___ Gall Bladder Problems
___ Jaundice
___ Hernia
___ Diarrhea
___ Constipation
___ Hemorrhoids
___ Appendicitis

RESPIRATORY
___ Difficulty Breathing
___ Chronic Cough
___ Spitting Phlegm
___ Spitting Blood
___ Wheezing/Asthma
___ Pneumonia
___ Tuberculosis

CARDIOVASCULAR
___ Irregular Heartbeat
___ High Blood Pressure
___ Pain over Heart
___ Previous Heart Trouble
___ Ankle Swelling
___ Varicose Veins
___ Rheumatic Fever
___ Stroke

GENITOURINARY
___ Frequent Urniation
___ Painful Urination
___ Blood in Urine
___ Kidney Disease
___ Urinary Infection
___ Inability to Control Urination
___ Difficulty Starting Urine
___ Get up _times per night
___ Breast Lump or pain

SKIN
___ Itching
___ Bruising Easy
___ Change in Mole
___ Skin Cancer

FAMILY HISTORY
___ Diabetes
___ Thyroid Disease/Goiter
___ Tuberculosis
___ Kidney Disease
___ High Blood Pressure
___ Heart Disease
___ Cancer
___ Muscle, Bone or Nerve Disease

NEUROLOGIC
___ Weakness
___ Twitching
___ Tremors
___ Headache
___ Fainting
___ Dizziness
___ Convulsions
___ Epilepsy
___ Numbness/Tingling
___ Arm/Leg Pain
___ Mental Disorder

MUSCULOSKELETAL
___ Neck Stiffness/Pain
___ Pain between Shoulders
___ Low Back Pain
___ Swollen Joints
___ Painful Joints
___ Muscle Aches/Soreness
___ Spinal Curvature
___ Arthritis

HABITS
___ Smoking ___ packs/day
___ years
___ Drinking
___ Recreational Drug Use

EXERCISE
___ None
___ 1-2 Times/Week
___ 3-5 Times/Week
___ 6-7 Times/Week
Type of Excersie?
_____

WOMEN ONLY
___ Painful Periods
___ Excessive Flows
___ Irregular Cycles
___ Hot Flashes
Date of Last Period
_____

MEN ONLY
___ Testicular Swelling/Pain
___ Prostate Problems

Medications, Date Started

_____

Previous Medications and Date stopped

_____

Surgeries/Hospitalizations and Dates

_____

Sleep Positions and How Long Do You Sleep at Night?

_____

Allergies

_____

Trauma History (Falls, Car Accidents, Sports Injuries)

_____

Family Doctor name, May we contact if necessary? Yes___ NO___

_____

Stress Level: (Circle) Low Medium High If High, why?_____