MEDICATIONS: ____________________

DRUG ALLERGIES: ____________________

- ☐ Ringing In Ear ________
- ☐ Ear Infections - *Frequent* ________
- ☐ Dizziness/Fainting ________
- ☐ Failing Vision ________
- ☐ Eye Infections ________
- ☐ Nose Bleeds ________
- ☐ Sinus Trouble ________
- ☐ Sore Throats - *Frequent* ________
- ☐ Hayfever/Allergies ________
- ☐ Pneumonia ________
- ☐ Bronchitis/Chronic Cough ________
- ☐ Asthma/Wheezing ________
- ☐ Chest Pain ________
- ☐ High Blood Pressure ________
- ☐ Heart Murmur ________
- ☐ Swollen Ankles ________
- ☐ Leg Pain - *Walking* ________
- ☐ Varicose Veins/Phlebitis ________
- ☐ Loss of Appetite ________
- ☐ Difficulty Swallowing ________
- ☐ Indigestion or Heartburn ________
- ☐ Persistent Nausea/Vomiting ________
- ☐ Peptic Ulcers ________
- ☐ Abdominal Pain - *Chronic* ________

- ☐ Gall Bladder Trouble ________
- ☐ Jaundice/Hepatitis ________
- ☐ Change in Bowel Habits ________
- ☐ Diarrhea ☐ Constipation ________
- ☐ Diverticulosis ☐ Crohn's/Colitis ________
- ☐ Bloody or Tarry Stools ________
- ☐ Hemorrhoids ________
- ☐ Hernia ________
- ☐ Urine Infections - *Frequent* ________
- ☐ Blood In Urine ________
- Urination- ☐ Overnight > than twice
  - ☐ Painful ☐ Loss of Control
  - ☐ Decrease in Force/Flow
- ☐ Kidney Stones ________
- ☐ Venereal Disease ________
- ☐ Urethral Discharge ________
- ☐ Chronic Fatigue ________
- ☐ Weight Loss - *Recent* ________
- ☐ Anemia ☐ Bruise Easily ________
- ☐ Cancer ________
- ☐ Diabetes ________
- ☐ Thyroid Disease ________
- ☐ Convulsions/Seizures ________
- ☐ Stroke ________

- ☐ Tremor/Hands Shaking ________
- ☐ Muscle Weakness ________
- ☐ Numbness/Tingling Sensations ________
- ☐ Headaches - *Frequent* ________
- ☐ Arthritis/Rheumatism ________
- ☐ Osteoporosis ________
- ☐ Back Pain - *Recurrent* ________
- ☐ Bone Fracture/Joint injury ________
- ☐ Gout ________
- ☐ Foot Pain ☐ Cold Numb Feet ________
- ☐ Rashes ☐ Hives ________
- ☐ Psoriasis ☐ Eczema ________
- ☐ Nervousness ☐ Depression ________
- ☐ Memory Loss ________
- ☐ Moodiness - *Excessive* ________
- ☐ Phobias ________
- ☐ Mental Illness ________
- ☐ Lactose Intolerance ________
- ☐ Prostate Disease ________
- ☐ Sexual/Menstrual Dysfunction ________
- ☐ Frequent Infections ________
- ☐ Diphtheria ________
- ☐ Tetanus ________
- ☐ Chicken Pox ☐ Polio ☐ Mumps ☐

Measles ☐ Rubella ☐ Rheumatic Fever
☐ Scarlet Fever ☐ Tuberculosis ☐ Herpes
☐ Other ________
☐ Other ________

Females - *Please Complete*

Pregnant? ☐ Yes ☐ No

Planning Pregnancy? ☐ Yes ☐ No

Menstrual Flow:

☐ Regular ☐ Irregular ☐ Pain/Cramps

___Days of Flow ___Length of Cycle

Date-1st day of last period______

☐ Pain/Bleeding during or after sex

Number of:

___Pregnancies ___Abortions

___Miscarriages ___Live Births

Birth Control Method________

B.C. Pill (Name) ________

☐ Flushing/Menopause

Date of Last PAP Test ________

☐ Normal ☐ Abnormal

Date of Last Mammogram

☐ Normal ☐ Abnormal

HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS				BLOOD DISEASE	
				GLAUCOMA	
				EPILEPSY	
SPOUSE				RHEUMATOID ARTHRITIS	
CHILDREN				TUBERCULOSIS	
				GOUT	
				HIGH BLOOD PRESSURE	
				HEART DISEASE	
				BACK PROBLEMS	