

Patient # \_\_\_\_\_

**Do you have or have you been treated for any of the following:**

- |  |  |
|--|--|
| <input type="checkbox"/> Abscess, subcutaneous (boil)        | <input type="checkbox"/> Headache, Migraine                        |
| <input type="checkbox"/> AIDS                                | <input type="checkbox"/> Headache, Not Specified                   |
| <input type="checkbox"/> Alcohol Dependency, current         | <input type="checkbox"/> Headache, Tension                         |
| <input type="checkbox"/> Allergy Syndrome (Allergies)        | <input type="checkbox"/> Hearing Impairment                        |
| <input type="checkbox"/> Alzheimer's                         | <input type="checkbox"/> Hemorrhoids (Piles)                       |
| <input type="checkbox"/> Anemia (Weak Blood)                 | <input type="checkbox"/> Hepatitis (Liver Infection or Irritation) |
| <input type="checkbox"/> Angina Syndrome, Stable Heart Pains | <input type="checkbox"/> Hiatal Hernia                             |
| <input type="checkbox"/> Anorexia                            | <input type="checkbox"/> Hypercholesterolemia                      |
| <input type="checkbox"/> Anxiety                             | <input type="checkbox"/> Hypertension (High Blood Pressure)        |
| <input type="checkbox"/> Arrhythmias                         | <input type="checkbox"/> Hyperthyroidism (Enlarged Thyroid Gland)  |
| <input type="checkbox"/> Arthritis, Nonspecific              | <input type="checkbox"/> Hypothyroidism                            |
| <input type="checkbox"/> Arthritis, Osteo                    | <input type="checkbox"/> Irritable Bowel Syndrome                  |
| <input type="checkbox"/> Arthritis, Rheumatoid               | <input type="checkbox"/> Kidney Disease                            |
| <input type="checkbox"/> Asthma                              | <input type="checkbox"/> Menstrual Disorder                        |
| <input type="checkbox"/> Atherosclerotic Heart Disease       | <input type="checkbox"/> Mental Disorder, Not Specified            |
| <input type="checkbox"/> Benign Prostatic Hypertrophy        | <input type="checkbox"/> Mononucleosis                             |
| <input type="checkbox"/> Bronchitis, Acute                   | <input type="checkbox"/> Murmur, Heart                             |
| <input type="checkbox"/> Bronchitis, Chronic                 | <input type="checkbox"/> Myocardial Infarction (Heart Attack)      |
| <input type="checkbox"/> Bulimia                             | <input type="checkbox"/> Otitis, Media                             |
| <input type="checkbox"/> Cancer                              | <input type="checkbox"/> Otitis, External                          |
| <input type="checkbox"/> Cataracts                           | <input type="checkbox"/> Pacemaker                                 |
| <input type="checkbox"/> Cerebrovascular Disease             | <input type="checkbox"/> Peptic Ulcer Disease                      |
| <input type="checkbox"/> COPD                                | <input type="checkbox"/> Phlebitis, Superficial Leg                |
| <input type="checkbox"/> Cirrhosis                           | <input type="checkbox"/> Pneumonia                                 |
| <input type="checkbox"/> Congestive Heart Failure            | <input type="checkbox"/> Prostatitis                               |
| <input type="checkbox"/> Constipation                        | <input type="checkbox"/> Psoriasis                                 |
| <input type="checkbox"/> Cyst, Ovarian                       | <input type="checkbox"/> Pyelonephritis                            |
| <input type="checkbox"/> Cystitis, Acute (Bladder Infection) | <input type="checkbox"/> Recovering Alcoholic                      |
| <input type="checkbox"/> Depression                          | <input type="checkbox"/> Renal Calculus (Kidney Stones)            |
| <input type="checkbox"/> Diabetes Mellitus, Type 1           | <input type="checkbox"/> Rheumatic Fever                           |
| <input type="checkbox"/> Diabetes Mellitus, Type 2           | <input type="checkbox"/> Seizure Disorder/Epilepsy                 |
| <input type="checkbox"/> Fracture, Bone-not specified        | <input type="checkbox"/> Sexually Transmitted Disease              |
| <input type="checkbox"/> Fibrocystic Breast Disease          | <input type="checkbox"/> Stress Syndrome                           |
| <input type="checkbox"/> Gall Stones/Cholelithiasis          | <input type="checkbox"/> Suicide Attempt                           |
| <input type="checkbox"/> GERD                                | <input type="checkbox"/> Tuberculosis                              |
| <input type="checkbox"/> Glaucoma (Increased Eye Pressure)   | <input type="checkbox"/> Urinary Tract Infection                   |
| <input type="checkbox"/> Goiter (Enlarged Thyroid Gland)     | <input type="checkbox"/> Varicose Veins                            |
| <input type="checkbox"/> Gout                                | <input type="checkbox"/> Vision Impairment                         |

**FAMILY HISTORY:**

**Father:** Alive \_\_\_\_\_ Deceased \_\_\_\_\_ Age at Death \_\_\_\_\_ Cause \_\_\_\_\_

Health History: \_\_\_\_\_

**Mother:** Alive \_\_\_\_\_ Deceased \_\_\_\_\_ Age at Death \_\_\_\_\_ Cause \_\_\_\_\_

Health History: \_\_\_\_\_