



MEDICAL HISTORY

FAMILY HISTORY

Y N Diabetes
 Y N High Blood Pressure
 Y N Heart Disease
 Y N Musculoskeletal disease
 Y N Cancer _____
 Y N Stroke/Aneurysm
 Y N Osteoporosis
 Y N Other: _____

CURRENT GENERAL HISTORY

Y N Unexplained Weight Change inc. or dec.
 Y N Allergies _____
 Y N Bleeding/Bruising
 Y N HIV
 Y N Cancer: _____
 Y N Insomnia
 Y N Other: _____

ENDOCRINE HISTORY

Y N Thyroid Condition Hyper/Hypo
 Y N Diabetes
 Y N Other: _____

EYE/EAR/NOSE/THROAT

Y N Eye or Ear Pain
 Y N Other Visual Conditions
 Y N Change in Vision/Hearing/Taste
 Y N Ringing in Ears
 Y N Dizziness
 Y N Difficulty chewing/Swallowing

GASTROINTESTINAL SYSTEM

Y N Anorexia/Bulimia
 Y N Constipation/Diarrhea
 Y N Nausea/Vomiting
 Y N Abdominal Pain/Swelling
 Y N Gallbladder Disease
 Y N Liver/Pancreatic Disease

URINARY SYSTEM

Y N Urinary Urgency/Pain
 Y N Difficulty Holding/Expelling
 Y N Kidney Disease/Stone/Pain
 Y N Prostate Issues
 Y N Pelvic Pain

CARDIOVASCULAR SYSTEM

Y N Heart Medications
 Y N Past Heart or Vascular Disease
 Y N Chest Discomfort/Pain

Y N Palpitations
 Y N Edema
 Y N High Blood Pressure
 Y N Blood Clot/Aneurysm/DVT
 Y N Sudden Calf Pain with Walking
 Y N Other: _____

SKIN/HAIR/NAILS

Y N Skin Cancer
 Y N Rashes/Itching/Lesions
 Y N Psoriasis

NEUROLOGICAL SYSTEM

Y N Headaches
 Y N Seizures/Epilepsy
 Y N Vertigo
 Y N Loss of Sensation
 Y N Head Trauma
 Y N Multiple Sclerosis
 Y N Vertebral Disc Condition
 Y N Anxiety/Bipolar/Depression

MUSCULOSKELETAL SYSTEM

Y N Osteoporosis/Fibromyalgia
 Y N Arthritis: _____
 Y N Scoliosis
 Y N Joint Pain/Stiffness/Swelling
 Y N Muscle Cramp/Soreness/Pain
 Y N Neck Pain
 Y N Upper/Mid Back Pain
 Y N low Back Pain
 Y N Shoulder/Arm/Hand Pain
 Y N Leg/Knee/Foot Pain
 Y N Fractures/Dislocation/Sprains
 Y N TMJ Issues

PULMONARY SYSTEM

Y N Asthma/Shortness of Breath
 Y N Apnea
 Y N Pneumonia
 Y N Cigarette Smoking
 Y N Respiratory Infections
 Y N Other: _____

IMPLANTS/ORTHOTICS

Y N Cardiac/Pacemakers
 Y N Joint Replacement/Pins/Plates/Screws

DIET/EXERCISE

Y N Consume Caffeine
 Y N Consume Alcohol

SIGNATURE: _____

DATE: _____