

Do you currently or have you had:

Please mark all that apply

	Current/Past	
More frequent urination	<input type="radio"/>	<input type="radio"/>
Pain or blood with urination	<input type="radio"/>	<input type="radio"/>
Kidney or bladder infection	<input type="radio"/>	<input type="radio"/>
Kidney stones	<input type="radio"/>	<input type="radio"/>
Recurrent abdominal pain	<input type="radio"/>	<input type="radio"/>
Ulcers	<input type="radio"/>	<input type="radio"/>
Heartburn	<input type="radio"/>	<input type="radio"/>
Swallowing problems	<input type="radio"/>	<input type="radio"/>
Hernia	<input type="radio"/>	<input type="radio"/>
Hemorrhoids	<input type="radio"/>	<input type="radio"/>

Do you currently or have you had:

Please mark all that apply

	Current/Past	
Arthritis or gout	<input type="radio"/>	<input type="radio"/>
Bursitis	<input type="radio"/>	<input type="radio"/>
Fractured bones	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>
Tremor	<input type="radio"/>	<input type="radio"/>
Passing out	<input type="radio"/>	<input type="radio"/>
Speech problems	<input type="radio"/>	<input type="radio"/>
Trouble concentrating	<input type="radio"/>	<input type="radio"/>
Diarrhea or constipation	<input type="radio"/>	<input type="radio"/>

Do you currently or have you had:

Please mark all that apply

	Current/Past	
Asthma	<input type="radio"/>	<input type="radio"/>
Eczema	<input type="radio"/>	<input type="radio"/>
Hay Fever	<input type="radio"/>	<input type="radio"/>
Sinus Problems	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
High cholesterol or triglycerides	<input type="radio"/>	<input type="radio"/>
Thyroid trouble	<input type="radio"/>	<input type="radio"/>
Liver trouble	<input type="radio"/>	<input type="radio"/>
Anemia	<input type="radio"/>	<input type="radio"/>
Bleeding or bruising tendency	<input type="radio"/>	<input type="radio"/>

Do you currently or have you had:

Please mark all that apply

	Current/Past	
Sleep Problems	<input type="radio"/>	<input type="radio"/>
Disabled	<input type="radio"/>	<input type="radio"/>
Nervous tension	<input type="radio"/>	<input type="radio"/>
Irritability	<input type="radio"/>	<input type="radio"/>
Mood Swings / changes	<input type="radio"/>	<input type="radio"/>

Do you currently or have you had:

Please mark all that apply

	Current/Past	
Low blood pressure	<input type="radio"/>	<input type="radio"/>
Racing, pounding heart	<input type="radio"/>	<input type="radio"/>
Ankle swelling	<input type="radio"/>	<input type="radio"/>
Lung or breathing problems	<input type="radio"/>	<input type="radio"/>
Pneumonia	<input type="radio"/>	<input type="radio"/>

Do you currently or have you had:

Please mark all the apply

	Current/Past	
History of trauma	<input type="radio"/>	<input type="radio"/>
Infection	<input type="radio"/>	<input type="radio"/>
Unexplained weight loss	<input type="radio"/>	<input type="radio"/>
Unusual fatigue	<input type="radio"/>	<input type="radio"/>
Dizziness / Poor balance	<input type="radio"/>	<input type="radio"/>
Vomited blood	<input type="radio"/>	<input type="radio"/>
Bloody or black stools	<input type="radio"/>	<input type="radio"/>
Change in appetite	<input type="radio"/>	<input type="radio"/>
Fevers	<input type="radio"/>	<input type="radio"/>
Night Sweats	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>
Chest Pain	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>
Chronic cough	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>
Heart disease or murmur	<input type="radio"/>	<input type="radio"/>
Loss of bowel or bladder control	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>
Muscle weakness or paralysis	<input type="radio"/>	<input type="radio"/>
Memory loss	<input type="radio"/>	<input type="radio"/>
Severe trauma	<input type="radio"/>	<input type="radio"/>
Direct head trauma	<input type="radio"/>	<input type="radio"/>
Lost consciousness	<input type="radio"/>	<input type="radio"/>
Poor coordination	<input type="radio"/>	<input type="radio"/>
Night pain	<input type="radio"/>	<input type="radio"/>
Difficulty Swallowing	<input type="radio"/>	<input type="radio"/>
Recent infection	<input type="radio"/>	<input type="radio"/>
History of osteoporosis	<input type="radio"/>	<input type="radio"/>
History of cancer	<input type="radio"/>	<input type="radio"/>
Difficulty breathing	<input type="radio"/>	<input type="radio"/>
Abdominal pain	<input type="radio"/>	<input type="radio"/>
Use of corticosteroids	<input type="radio"/>	<input type="radio"/>
Use of anticoagulants	<input type="radio"/>	<input type="radio"/>
Use of birth control pills	<input type="radio"/>	<input type="radio"/>
Numbness in groin (saddle anesthesia)	<input type="radio"/>	<input type="radio"/>
Loss of anal sphincter tone, fecal incontinence (bowel accidents)	<input type="radio"/>	<input type="radio"/>
Pain fails to improve with rest	<input type="radio"/>	<input type="radio"/>
Pain greater than 4 weeks	<input type="radio"/>	<input type="radio"/>
Prolonged use of corticosteroids	<input type="radio"/>	<input type="radio"/>
Intravenous drug use	<input type="radio"/>	<input type="radio"/>

Family History

Please note any family history of any of the below Conditions and include relationship of relative to you

- Cancer _____
- Diabetes _____
- Headaches _____
- High Blood pressure _____
- Arthritis _____
- Epilepsy _____
- Heart Disease _____
- Stroke _____
- Spine or Back Disorder _____
- Multiple Sclerosis _____
- Psychological Problems _____

SERIOUS ILLNESSES: List current and past illnesses not mentioned above. (Including cancer, diabetes, etc.)

1. _____
2. _____
3. _____
4. _____

Signature _____

Date _____