Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect a thorough diagnosis, treatment plan and possibility of being accepted for care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Appendicitis
- ☐ Scarlet Fever
- ☐ Diptheria
- ☐ Typhoid Fever
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Malaria
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Eczema
- ☐ Stroke or family history of

CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Swollen Joints/Stiffness
- ☐ Walking Problems
- ☐ Difficulty Chewing
- ☐ Clicking Jaw

NERVOUS SYSTEM

- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Trouble
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

GENITO-URINARY

- ☐ Painful/Excessive Urination
- ☐ Discolored Urine
- ☐ Inability to Control Urination

C-V-R

- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Cardiovascular Disease
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ High/Low Blood Pressure
- ☐ Chronic Coughing
- ☐ Difficulty Breathing
- ☐ Asthma
- ☐ Chronic Congestion

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

MALE / FEMALE

- ☐ Taking Oral Contraceptives
- ☐ Previous Miscarriage
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain/Infections
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Genital Herpes
- ☐ Are You Pregnant? ☐ No ☐ Yes ☐ Maybe
- ☐ When Was Your Last Period? _____

GENERAL

- ☐ Allergies
- ☐ Sinus Problems
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Bruises Easily

Patient's Signature _____

Doctor's Signature _____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbols.

Ache Burning Numbness

Pins and Needles Stabbing Other