Please list health history, the condition and the relative (i.e., Mother, Father, Sister, Brother, Son, Daughter, etc.)

(Health Condition)	(Relative)
______________	______________
______________	______________
______________	______________

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
☐	☐ Headaches	☐	☐ High Blood Pressure	☐	☐ Diabetes
☐	☐ Neck Pain	☐	☐ Heart Attack	☐	☐ Excessive Thirst
☐	☐ Upper Back Pain	☐	☐ Chest Pains	☐	☐ Frequent Urination
☐	☐ Mid Back Pain	☐	☐ Stroke	☐	☐ Smoking/Tobacco Use
☐	☐ Low Back Pain	☐	☐ Angina	☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain	☐	☐ Kidney Stones	☐	☐ Allergies
☐	☐ Elbow/Upper Arm Pain	☐	☐ Kidney Disorder	☐	☐ Depression
☐	☐ Wrist Pain	☐	☐ Bladder Infection	☐	☐ Systemic Lupus
☐	☐ Hand Pain	☐	☐ Painful Urination	☐	☐ Epilepsy
☐	☐ Hip Pain	☐	☐ Loss of Bladder Control	☐	☐ Dermatitis/Eczema/Rash
☐	☐ Upper Leg Pain	☐	☐ Prostate Problems	☐	☐ HIV/AIDS
☐	☐ Knee Pain	☐	☐ Abnormal Weight Gain/Loss		
☐	☐ Ankle/Foot Pain	☐	☐ Loss of Appetite	Other:______________	
☐	☐ Jaw Pain	☐	☐ Abdominal Pain	______________	
☐	☐ Joint Pain/Stiffness	☐	☐ Ulcer	______________	
☐	☐ Arthritis	☐	☐ Hepatitis	______________	
☐	☐ Rheumatoid Arthritis	☐	☐ Liver/Gall Bladder Disorder		
☐	☐ Cancer	☐	☐ General Fatigue		
☐	☐ Tumor	☐	☐ Muscular In-coordination		
☐	☐ Asthma	☐	☐ Visual Disturbances		
☐	☐ Chronic Sinusitis	☐	☐ Dizziness		

PRESCRIBED MEDICATIONS: Check here if not taking any medications: ☐

Medication:	Strength:	MD's Instructions:
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

Supplements/Vitamins: Check here if not taking any supplements/vitamins: ☐

Supplement/Vitamin:

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Are you allergic to any medications? Please list each drug on a new line: Check here if you have no allergies: ☐

Name of Drug: Symptom: Severity (Mild, Moderate, Severe):

_____________________/_______________________/__________________________________

_____________________/_______________________/__________________________________

_____________________/_______________________/__________________________________

List all surgical procedures you have had:

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