NAME:_____ DATE:_____

CIRCLE CURRENT CONDITIONS…..CHECK FORMER CONDITIONS

GENERAL SYMPTOMS
allergy
chills
confusion
convulsions
dizziness
fainting
fatigue
fever
headache
loss of sleep
loss of weight
nervousness
sweats

CARDIOVASCULAR
chest pain
hardening of arteries
heart attack
high blood pressure
low blood pressure
poor circulation
rapid heartbeat
slow heartbeat
swelling of ankles

SKIN
acne
bruise easily
dermatitis
dryness
hives
sensitive skin
skin eruptions (rash)
varicose veins

RESPIRATORY
asthma
chest pain
chronic cough
difficulty breathing
pneumonia
shortness of breath
spitting up blood
spitting up phlegm
wheezing

MUSCLE & JOINT
(other than why you're here)
arthritis
backache: upper/mid/low
faulty posture
foot problems
headaches
jaw pain
numbness: arms / hands
numbness: legs/ feet
spinal curvature
stiff neck
swollen joints

GENITO-URINARY
bed wetting
bladder problems
blood in urine
frequent urination
kidney infection/stones
loss of bladder control
painful urination
prostate problems
pus in urine

GASTROINTESTINAL
colon trouble
constipation
diarrhea
difficult digestion
distension of abdomen
excessive hunger
excessive thirst
gallbladder problems
gas: upper or lower
hemorrhoids or piles
liver problems
nausea
poor appetite
stomach pain
vomiting

EYES, EARS, NOSE & THROAT
eye pain
failing vision
farsightedness
nearsightedness
deafness
earache
ear discharge
ear noises
nasal drainage
nose bleeds
nasal obstruction
sinus infections
frequent colds
gum trouble
hay fever
hoarseness
sore throat
swollen glands
tonsillitis

FEMALE
date of last period_____
congested breasts
cramps / backache
excessive flow
hot flashes
irregular cycle
lumps in breast
menopausal symptoms
miscarriage
painful menstrual period
pregnant
vaginal discharge

OTHER CONDITIONS
chickenpox
depression
diptheria
epilepsy
HIV/AIDS
malaria
measles
mumps
pneumonia
scarlet fever
smallpox
typhoid fever
venereal infection

other: (please list)

_____

_____

_____

HABITS:
Alcohol
Coffee
Tobacco
Drugs
Other_____

DATE OF LAST (Approx):
_____Physical Examination
_____Blood Test
_____Chest X-Ray
_____Spine X-Ray
_____Dental X-Ray
_____Urine Test

HAVE YOU EVER:
Y / N Been Knocked Unconcious?
Y / N Used Crutches or Other Support?
Y / N Been Treated for Nerve Disorder
Y / N Had a Fractured Bone?
Y / N Been Hospitalized for Other than Surgery?

CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS

__Alcoholism	__Diabetes	__Gout	__Polio	__Tuberculosis
__Anemia	__Eczema	__Heart Disease	__Rheumatic Fever	__Ulcers
__Appendicitis	__Emphysema	__Miscarriage	__Stroke	
__Cancer	__Goiter	__Multiple Sclerosis	__Thyroid problems	

FAMILY HISTORY: (for example: Cancer / Diabetes / Heart problems / Back or Neck problems)

Mother: _____ Father: _____

Sister(s): _____ Brother(s): _____