

If you have ever had a listed symptom in the past, please check that symptom in the Past Column. If you are presently troubled by a particular symptom, check that symptom in the Present column. If none apply leave blank.

<b>Past</b>	<b>Present</b>	<b>Condition</b>	<b>Past</b>	<b>Present</b>	<b>Condition</b>
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain (R__L__)	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow (R__L__)	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain (R__L__)	<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain (R__L__)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack - Date _____
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke - Date _____
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip (R__L__)	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee (R__L__)	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, Explain _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot (R__L__)	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Swelling, Stiffness of Joint(s)	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (Chronic Lung Disorders)
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gallbladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Noises)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight ____Gain____Loss	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders (by condition)
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow	<input type="checkbox"/>	<input type="checkbox"/>	HIV/Aids
<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Breast ____Soreness ____Lumps	If a family member has had any of the following,		
<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	please mark the appropriate box:		
<input type="checkbox"/>	<input type="checkbox"/>	PMS	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Chronic Back Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic Headaches	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lupus	
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/> Lung Problems	<input type="checkbox"/> Other _____	
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/irregular bowel habits	<input type="checkbox"/> High Blood Pressure _____		
<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon			

**Patient's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_