

Condition

Past Treatment

C. _____

How does this condition affect you? _____

D. _____

How does this condition affect you? _____

3. Do you have any reason to believe that you are pregnant? Yes No

4. Do you have any chronic infectious diseases? Yes No If yes, please explain: _____

5. Are you currently suffering from any chronic illness? Yes No If yes, please explain: _____

6. If applicable, list any foods, drugs or medications you are hypersensitive or allergic to. Please include the type of reaction: _____

7. Please circle any of the following medication that you are currently taking:

- | | | | | |
|-------------|----------------|----------------|--------------------|---------------------------|
| Laxatives | Pain Relievers | Antacids | Thyroid Medication | Appetite Suppressants |
| Antibiotics | Tranquilizers | Sleeping Pills | Cortisone | Blood Pressure Medication |

8. Please list any prescription medications, over-the-counter medications, vitamins and supplements that you are currently taking:

1. _____ 3. _____

2. _____ 4. _____

9. **Height:** _____ **Current Weight:** _____ **Past Maximum Weight:** _____ **When?** _____

10. **Blood Pressure:** What was your most recent blood pressure reading? _____/_____
When was this reading taken? _____.

11. **Childhood or Adult Illnesses** (please circle any that apply to you):

- | | | | | |
|----------------|---------------|-----------------|-------------|---------|
| Scarlet Fever | Diphtheria | Rheumatic Fever | Mumps | Measles |
| German Measles | Streptococcus | Staphylococcus | Chicken Pox | MRSA |

12. **Immunizations** (please circle any that you have had):

- | | | | |
|-----------------------|--------------|-----------|------------|
| Polio | Tetanus | Pertussis | Diphtheria |
| Measles/Mumps/Rubella | Other: _____ | | |

13. Hospitalizations and Surgeries:

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____

14. X-Rays/CAT Scans/MRI's/NMR's/Special Studies:

Reason	When	Reason	When
_____	_____	_____	_____
_____	_____	_____	_____

15. Family History:

	Mother	Father	Brothers	Sisters	Spouse	Children
Age, if living:						
Health (G=good, P=poor):						
Age at death (if deceased):						
Cause of death:						

Check any conditions that apply to members of your family:

	Mother	Father	Brothers	Sisters	Spouse	Children
Cancer:						
Diabetes:						
Heart Disease:						
High Blood Pressure:						
Stroke:						
Mental Illness:						

16. Emotional (please circle any that you experience now and underline any that you have experienced in the past):

Mood Swings Nervousness Anxiety Mental Tension

17. Energy and Immunity (please circle any that you experience now and underline any that you have experienced in the past):

Frequent Common Cold Slow Wound Healing Chronic Infections Fatigue

Chronic Fatigue Syndrome

18. **Head, Eye, Ear, Nose and Throat** (please circle any that you experience now and underline any that you have experienced in the past):

Impaired Vision	Eye Pain/Strain	Glaucoma	Glasses/Contacts
Tearing/Dryness	Impaired Hearing	Ear Ringing	Earaches
Headaches	Sinus Problems	Nose Bleeds	Frequent Sore Throats
Teeth Grinding	TMJ/Jaw Problems	Hay Fever	

19. **Respiratory** (please circle any that you experience now and underline any that you have experienced in the past):

Pneumonia	Frequent Common Colds	Difficulty Breathing	Emphysema
Persistent Cough	Pleurisy	Asthma	Tuberculosis
Shortness of Breath	Other Respiratory Problems: _____		

20. **Cardiovascular** (please circle any that you experience now and underline any that you have experienced in the past):

Heart Disease	Chest Pain	Swelling of Ankles	High Blood Pressure
Stroke	Heart Murmurs	Rheumatic Fever	Varicose Veins
Palpitations/Fluttering			

21. **Gastrointestinal** (please circle any that you experience now and underline any that you have experienced in the past):

Ulcers	Changes in Appetite	Nausea/Vomiting	Epigastric Pain
Passing Gas	Heartburn	Belching	Gall Bladder Disease
Liver Disease	Hepatitis B or C	Hemorrhoids	Abdominal Pain
Stool:	Diarrhea	Constipation	Undigested Food
Mucous in Stool	Blood in Stool		

22. **Genito-Urinary Tract** (please circle any that you experience now and underline any that you have experienced in the past):

Kidney Disease	Painful Urination	Frequent Urination	Venereal Disease
Kidney Stones	Impaired Urination	Frequent Urination at Night	
Frequent Urinary Tract Infections			

23. **Female Reproductive/Breasts** (please circle any that you experience now and underline any that you have experienced in the past):

Irregular Cycles Heavy Flow Clotting Vaginal Discharge
Bleeding Between Cycles Difficulty Conceiving Menopausal Symptoms Difficulty Conceiving
Nipple Discharge Breast Lumps/Tenderness

24. **Menstrual/Birthing History:**

A. Age of First Menses: _____ D. # of Pregnancies: _____ G. # of Abortions: _____
B. # of Days of Menses: _____ E. # of Miscarriages: _____ H. # of Live Births
C. Length of Cycle: _____ F. Birth Control: _____

25. **Male Reproductive** (please circle any that you experience now and underline any that you have experienced in the past):

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge

26. **Musculoskeletal** (please circle any that you experience now and underline any that you have experienced in the past):

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain
Mid Back Pain Low Back Pain Leg Pain
Joint Pain (if so, where?): _____

27. **Neurologic** (please circle any that you experience now and underline any that you have experienced in the past):

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance
Seizures/Epilepsy

28. **Endocrine** (please circle any that you experience now and underline any that you have experienced in the past):

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Mellitus
Night Sweats Feeling Hot or Cold

29. **Skin** (please circle any that you experience now and underline any that you have experienced in the past):

Rashes Eczema/Hives Psoriasis

30. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia Cancer Cold Hands/Feet

Do you have any chronic infectious diseases? _____

Is there anything else we should know? _____

31. Lifestyle:

A. Please indicate typical food intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

B. Daily Exercise: _____

C. Sleep Habits: _____

E. Occupation: _____ Employer: _____ Hours/Week: _____

Do you enjoy work? Yes No Why/Why not? _____

F. Nicotine/Alcohol/Caffeine Use: _____

G. Have you experienced any major traumas? Yes No Explain: _____

H. Daily Consumption of Liquids: _____

I. Television Habits: _____

J. Reading Habits: _____

K. Interests and Hobbies: _____