FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Allergies/Asthma						
Arthritis						
Back Trouble						
Bleeding Troubles						
Birth Defects						
Bursitis						
Cancer						
Constipation						
Depression/Mental Illness						
Diabetes						
Disc Problems						
Emphysema						
Epilepsy/Seizures						
Gallstones						
Glaucoma						
Headaches/Migraines						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Nervousness						
Neuritis/Neuralgia						
Osteoporosis						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble/Ulcers						
Thyroid Disease						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

PATIENT HISTORY

PERSONAL HISTORY

Patient_____ Date_____

Childhood Diseases: Measles_____ Mumps_____ Chicken Pox_____ Others_____

Unusual Childhood Diseases:_____

Adult Illnesses or Conditions: _____

Are you allergic to any drugs or medications?_____

Patient's Signature_____

CHIEF SYMPTOMS

Have you seen any other doctors for this condition?_____
Is the condition due to injury or sickness arising out of employment? _____
Is the condition due to injury or sickness arising out of an auto or other accident? _____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter Y for YES and N for NO (or leave blank).

Y = YES N/or Blank = No/Never

DIAGNOSED WITH THE FOLLOWING

Skin/Hair/Nail _____
Mouth/Throat _____
Nose/Sinus _____
Ear Problems _____
Eye Problems _____
Chest/Lung/Breathing _____
Smoke _____ How Much _____
Heart/Blood Vessel _____
Blood/Lymph Problems _____
Digestive Problems _____
Genital (Prostate/Vaginal) _____
Urinary/Kidney/Bladder _____
Physically Abused _____
Nervous System Diseases _____
Mental Health Problems _____
Gland/Hormone _____
Allergy/Immunity _____
Muscle/Tendon/Ligament _____
Bone/Joint Disease _____
Recurring Headaches _____
Losing/Gaining Weight _____
Pain wake you at night _____
Bowel/Bladder Changes _____
Sore that doesn't heal _____
Unusual Bleeding/ Discharge _____
Lump in Breast or Elsewhere _____
Indigestion/Swallowing _____
Change in Wart or Mole _____
Nagging Cough/ Hoarseness _____
Loss of Bladder Control _____
Loss of Bowel Control _____
Temporary Loss of Vision in one eye _____
Blood in Urine _____
Claustrophobia _____
Spinal Surgery _____
Common Cold/Flu _____
Carotid Artery Surgery _____
Forceps Delivery _____
Detached Retina _____
Stroke _____
Slipped Disc _____
Herniated Disc _____
Osteoporosis _____
TIA's (mini Strokes) _____
Drop Attacks (collapse but no fainting) _____
Hardening of Arteries _____
Partial/Complete Paralysis _____
Rheumatoid Arthritis _____
Fractured/Broken Vertebrae _____
Bleeding Disorder _____
Nervous System Disorder _____
High Blood Pressure _____
Blood in Stool _____
Cancer _____
Kidney Disease _____
Prostate Disease _____

PAST MONTH

Nausea _____
Vomiting _____
Vertigo/Spinning _____
Difficulty Walking _____
Lack of Coordination _____
Headaches/Migraines _____
Numbness/Sensory _____
Loss of Consciousness _____
Double Vision _____
Blurred Vision _____
Tinnitus/Ringing Ears _____
Speech Problems _____
Clumsiness _____
Memory Loss _____
Personality Changes _____
Fever _____
Diarrhea _____
Loss of Strength _____
Head Trauma _____

WOMEN ONLY:

Menstrual Problems _____
Birth Control Pills _____
Pregnant _____
Breast Problems _____
Breast Removal _____

LIFESTYLE

Diet
- Balanced _____
- Fair _____
- Poor _____
- Excessive _____
- Restricted _____

Do you use
- Caffeine _____
- Tobacco _____
- Nicotine _____
- Recreational rug_____
- Soda _____

Type of Work
- Professional _____
- Physical Labor _____
- Driver _____
- Clerical _____
- Factory _____
- Homemaker _____
- Retail Store _____
- Construction _____

Demands of Job
- Heavy _____
- Moderate _____
- Light _____

Stress Levels
- High _____
- Medium _____
- Low _____

Exercise
- Vigorous _____
- Moderate _____
- Light _____