Name: _____

Patient History

Please check if you have ever had any of these conditions

HEENT		Urogenital		Endocrine	
Glaucoma		Prostate Disease		Adult Onset Diabetes	
Chronic Sinusitis		Testicular Cancer		Insulin Dependent Diabetes	
Eye Disorders		Ovarian Cancer		Hyperthyroidism	
Temporomandibular		Cervical Cancer		Hypothyroidism	
Hearing Loss		Endometriosis		Gout	
Respiratory		Kidney Stones		Poryphyria	
Chronic Obstruct Pulmonar		Incontinence		**Bone Fractures**	
Emphysema		Uterine Prolapsed Uterus		Cervical (Neck)	
Asthma		Uterine Fibroid		Thoracic (Middle Back)	
Lung Cancer		Menopause		Lumbar (Low Back)	
Pleurisy		End Stage Renal Dis.		Shoulder R / L	
Cardiovascular		**Muscle Skel/Connective Tissue**		Wrist R / L	
Coronary Artery Disease		Scoliosis		Ribs	
Myocardial Infarction		Arthritis		Sternum	
Angina		Rheumatoid Arthritis		Pelvic	
Congestive Heart Failure		Fibromyalgia		Hip R / L	
Hypertension - high BP		Lupus		Femur R / L	
Hypotension - low BP		Scleroderma		Knee Cap R / L	
Atrial Fibrillation		Systemic Sclerosis		Tibia/Fibula (Shin) R / L	
High Cholesterol		Osteoarthritis		Foot R / L	
High Triglycerides		Ostesopenia		Hand R / L	
Gastrointestinal		Osteoporosis		**Neurological**	
GERD		**Psychiatric**		Migraines	
Hiatal Hernia		Depression		Headaches	
Peptic Ulcer Disease		Schizophrenia		Cerebral Vascular Disease	
Liver Disease		Bi-Polar Disorder		Brain Tumor	
Hepatitis		Anxiety		Epilepsy	
Fatty Liver		Post Traumatic Stress		Seizure Disorder	
Gallbladder Disease		Hypochondrias		Fainting Spells	
Chronic Pancreatitis		OCD		Numbness in Upper Extre	
Crohns Disease		Anorexia Nervosa		Numbness in Lower Extre	
Ulcerative Colitis		Bulimia Nervosa		Multiple Sclerosis	
Irritable Bowel Syndrome		Chronic Fatigue Syndr.		Muscular Dystrophy	
Colitis		**Hematological/Lymphatic**		Spina Bifida	
Stomach Cancer		Anemia		Dementia	
Bowel Cancer		Hodgkin's Disease		Alzheimer's Disease	
Colorectal Cancer		Non-Hodgkin's Lymphoma		Parkinson's Disease	
Colonic Polyps		Sickle Cell Disease		Insomnia	
Diverticular Disease		Breast Cancer		Sleep Apnea	
Chronic Diarrhea		Leukemia		Carpel Tunnel Syndrome	
Chronic Constipation		AIDS		**Other**	
Abdominal Aortic Aneurysm		HIV		1	
Skin		Deep Venous Thrombosis		2	
Dermatitis		**Immuno/Allergic**		3	
Eczema		Hypersensitivity Disor.		4	
Melanoma (Skin Cancer)		Transplant		5	

When did your symptoms start? _____

Please provide a brief description of how your symptoms started and its progression to date:

_____

_____

_____