Personal Health History Name: _____ Date/Updated: / / / / / /

CONSTITUTION:
_____ Developmental Disabilities
_____ Cancer
_____ Fatigue Syndrome
_____ Other _____
_____ **None of the Above**

ENT:
_____ Hearing Loss
_____ Sinusitis
_____ Dry Mouth
_____ Laryngitis
_____ Other _____
_____ **None of the Above**

NEURO:
_____ Multiple Sclerosis
_____ Epilepsy
_____ Cerebral Palsy
_____ Tumor
_____ Stroke/CVA
_____ Migraine
_____ Autism Spectrum Disorder
_____ Other _____
_____ **None of the Above**

PSYCH:
_____ Depression
_____ Attention Defecit
_____ Anxiety
_____ Bipolar Disorder
_____ Other _____
_____ **None of the Above**

CARDIOVASCULAR:
_____ Hypertension
_____ Stroke/VCA
_____ Heart Disease
_____ Vascular Disease
_____ Congestive Heart Failure
_____ Other _____
_____ **None of the Above**

RESPIRATORY:
_____ Cigarette Smoker
_____ Asthma
_____ Bronchitis
_____ Emphysema
_____ Chronic Obstruction
_____ Sleep Apnea
_____ Other _____
_____ **None of the Above**

GI:
_____ Crohn's
_____ Colitis
_____ Ulcer
_____ Acid Reflux
_____ Celiac Disease
_____ Other _____
_____ **None of the Above**

GU:
_____ Kidney Disease
_____ Prostate Disease/Cancer
_____ STD-Herpes/Chlamydia
_____ Benign Prostate Hypertrophy
_____ Pregnant
_____ Nursing
_____ Other _____
_____ **None of the Above**

ALLERGY/IMMUNE:
_____ Drug/Environmental Allergies
_____ Rheumatoid Arthritis
_____ Lupus
_____ Sjogren's Syndrome
_____ Other _____
_____ **None of the Above**

MUSCULOSKELETAL:
_____ Arthritis
_____ Osteoarthritis
_____ Fibromyalgia
_____ Muscular Dystrophy
_____ Ankylosing Spondylitis
_____ Osteoporosis
_____ Gout
_____ Other _____
_____ **None of the Above**

INTEG:
_____ Ezcema
_____ Rosacea
_____ Psoriasis
_____ Cold Sores
_____ Shingles
_____ Other _____
_____ **None of the Above**

ENDO:
_____ Type 1 Diabetes
_____ Type 2 Diabetes
_____ Thyroid Dysfunction
_____ Hormonal Dysfunction
_____ Other _____
_____ **None of the Above**

HEM/LYMPH:
_____ Anemia
_____ Large-Volume Blood Loss
_____ Ulcer
_____ Hypercholesterolemia
_____ Other _____
_____ **None of the Above**

FAMILY HISTORY
Please Mark: Mom, Dad, Brother Sister, Son or Daughter

Cancer _____
Type 1 Diabetes _____
Type 2 Diabetes _____
Hyperthyroid _____
Hypertension _____
Hypothyroid _____

Cataract _____
Macular Degeneration _____
Glaucoma _____
Other _____

Alcohol Use: Yes OR No
Frequency: _____
Tobacco Use: Yes OR No
Cigarettes Cigars Pipe OR Other
Amount: _____
Former Smoker: Yes OR No
Recreational Drugs: Yes OR No

LIST ALL DRUG & OTHER ALLERGIES: LATEX SENSITIVITY Yes OR No

_____
_____
_____

Please List All Medications/Supplements (Rx and OTC) or Attach List

Name						
Dose						
Route						
Freq.						

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