

HEALTH: CHECK ALL THAT APPLY

GENERAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	<input type="checkbox"/>	Excessive appetite
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Fevers
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Sweat easily
<input type="checkbox"/>	<input type="checkbox"/>	Chills
<input type="checkbox"/>	<input type="checkbox"/>	Localized weakness
<input type="checkbox"/>	<input type="checkbox"/>	Poor coordination
<input type="checkbox"/>	<input type="checkbox"/>	Bleed or bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	Catch cold easily
<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite
<input type="checkbox"/>	<input type="checkbox"/>	Strong thirst
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

SKIN & HAIR

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Rashes
<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Pimples
<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	Tumors, lumps

HECK & NECK

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Neck stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged lymph glands
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Concussions
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

EARS

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Infection
<input type="checkbox"/>	<input type="checkbox"/>	Ringing
<input type="checkbox"/>	<input type="checkbox"/>	Decreased hearing
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

EYES

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	<input type="checkbox"/>	Visual changes
<input type="checkbox"/>	<input type="checkbox"/>	Poor night vision
<input type="checkbox"/>	<input type="checkbox"/>	Spots
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Glasses / contacts
<input type="checkbox"/>	<input type="checkbox"/>	Eye inflammation
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

NOSE, THROAT, MOUTH

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds
<input type="checkbox"/>	<input type="checkbox"/>	Sinus infections
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever or allergies
<input type="checkbox"/>	<input type="checkbox"/>	Recurring sore throats
<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing

CARDIOVASCULAR

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Blood clots
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat
<input type="checkbox"/>	<input type="checkbox"/>	Cold hands / feet
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands / feet
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

RESPIRATORY

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds
<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive
<input type="checkbox"/>	<input type="checkbox"/>	Pulmonary disease
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood
<input type="checkbox"/>	<input type="checkbox"/>	Production of phlegm
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

GASTRO-INTESTINAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Belching
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools/black
<input type="checkbox"/>	<input type="checkbox"/>	Stools
<input type="checkbox"/>	<input type="checkbox"/>	Bad breath
<input type="checkbox"/>	<input type="checkbox"/>	Rectal pain
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Pain or cramps
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disorder
<input type="checkbox"/>	<input type="checkbox"/>	Gas
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

GENITO-URINARY

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	Pain or urination
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Urgency to urinate
<input type="checkbox"/>	<input type="checkbox"/>	Unable to hold urine
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

MALE

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Pain / itching genitalia
<input type="checkbox"/>	<input type="checkbox"/>	Genital lesions/ discharge
<input type="checkbox"/>	<input type="checkbox"/>	Impotence
<input type="checkbox"/>	<input type="checkbox"/>	Weak urinary stream
<input type="checkbox"/>	<input type="checkbox"/>	Lumps in testicles
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

FEMALE

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urinary tract infections
<input type="checkbox"/>	<input type="checkbox"/>	Frequent vaginal infections
<input type="checkbox"/>	<input type="checkbox"/>	Pain / itching of genitalia
<input type="checkbox"/>	<input type="checkbox"/>	Genital lesions / discharge
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic inflammatory disease
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal pap smear
<input type="checkbox"/>	<input type="checkbox"/>	Irregular menstrual periods
<input type="checkbox"/>	<input type="checkbox"/>	Painful menstrual periods
<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps
<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

NEUROLOGICAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling of limbs
<input type="checkbox"/>	<input type="checkbox"/>	Concussion
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

PSYCHOLOGICAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety / stress
<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Treated for emotional or
<input type="checkbox"/>	<input type="checkbox"/>	Psychological problems
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

INFECTION SCREENING

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	TB
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea
<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia
<input type="checkbox"/>	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	<input type="checkbox"/>	Genital warts
<input type="checkbox"/>	<input type="checkbox"/>	Herpes: oral
<input type="checkbox"/>	<input type="checkbox"/>	Herpes: genital

MUSCULAR-SKELETAL

<u>Past</u>	<u>Current</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Stiff neck / shoulders
<input type="checkbox"/>	<input type="checkbox"/>	Low back pain
<input type="checkbox"/>	<input type="checkbox"/>	Back pain
<input type="checkbox"/>	<input type="checkbox"/>	Muscle spasm, twitching, cramps
<input type="checkbox"/>	<input type="checkbox"/>	Sore, cold or weak knees
<input type="checkbox"/>	<input type="checkbox"/>	Joint pain