



Surgeries (please include date of procedure)

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Allergies (chemical, environmental, food, drugs, etc.)

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Medications (names & dosages) Please attach an additional page if necessary.

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Vitamins/Supplements/Herbs

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Exercise

Days per week	Length of workout	Type of Activity
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Diet

Meals per day	Snacks	Caffeinated Drinks	Alcohol per week
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**Personal History** Please check any conditions or symptoms you have now or have had in the past.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Arthritis               | <input type="checkbox"/> Liver/Gall Bladder Disease | <input type="checkbox"/> Stroke                     | <input type="checkbox"/> Heart Disease              |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Hypo/Hyperglycemia         | <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Elevated Blood Cholesterol |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Food Allergies/Intolerance | <input type="checkbox"/> Diverticulitis/IBS         |
| <input type="checkbox"/> Ulcer                   | <input type="checkbox"/> Seizures                   | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> Raynaud's Disease          |
| <input type="checkbox"/> Chronic Fatigue         | <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Thyroid Imbalance          | <input type="checkbox"/> Respiratory Allergies      |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Lyme Disease               | <input type="checkbox"/> Chronic Pain Condition     | <input type="checkbox"/> Impotence                  |
| <input type="checkbox"/> Gastritis/Pancreatitis  | <input type="checkbox"/> Asthma                     | <input type="checkbox"/> Infertility                | <input type="checkbox"/> Emphysema                  |
| <input type="checkbox"/> Bleeding Tendency       | <input type="checkbox"/> Migraines                  | <input type="checkbox"/> Nervous Disorders          | <input type="checkbox"/> STD (which? _____)         |
| <input type="checkbox"/> Meningitis              | <input type="checkbox"/> Hepatitis                  | <input type="checkbox"/> HIV/AIDS                   | <input type="checkbox"/> Syphilis                   |

**Family Medical History** Please check any condition that applies to your immediate family. Put an F (father), M (mother), S (sister), B (brother), GM (grandmother), GF (grandfather) next to choice.

- |  |  |  |                                       |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Diabetes _____            | <input type="checkbox"/> Seizures _____  | <input type="checkbox"/> Heart Disease _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Cancer _____        | <input type="checkbox"/> Asthma _____ |
| <input type="checkbox"/> Other _____               |  |  |                                       |
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Please **check** if you have had any of these items listed below in the last year  
Put a **star** on the box if you had this in the past but do not any longer.

**General**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Poor Appetite           | <input type="checkbox"/> Poor Sleeping      | <input type="checkbox"/> Fatigue                            | <input type="checkbox"/> Fevers              |
| <input type="checkbox"/> Chills                  | <input type="checkbox"/> Night Sweats       | <input type="checkbox"/> Sweats Easily                      | <input type="checkbox"/> Tremors             |
| <input type="checkbox"/> Cravings                | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Poor Balance                       | <input type="checkbox"/> Change in appetite  |
| <input type="checkbox"/> Bleed/Bruise easily     | <input type="checkbox"/> Weight loss/gain   | <input type="checkbox"/> Peculiar tastes/smells             | <input type="checkbox"/> Dental/gum problems |
| <input type="checkbox"/> Muscle weakness/fatigue | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Strong thirst (hot or cold drinks) |  |

**Skin and Hair**

- |   |                                      |   |  |
|---|--------------------------------------|---|--|
| <input type="checkbox"/> Rashes             | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Hives/Allergic Dermatitis                          | <input type="checkbox"/> Itching           |
| <input type="checkbox"/> Eczema/Psoriasis   | <input type="checkbox"/> Dandruff    | <input type="checkbox"/> Loss of hair <input type="checkbox"/> Recent moles |  |
| <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Acne        | <input type="checkbox"/> Change in skin/hair texture                        | <input type="checkbox"/> Face flushing     |
| <input type="checkbox"/> Dermatitis         | <input type="checkbox"/> Warts       | <input type="checkbox"/> Fungal Infection                                   | <input type="checkbox"/> Weak or ridged na |

**Head, Eyes, Ears, Nose and Throat**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Difficulty swallowing        | <input type="checkbox"/> Migraines  | <input type="checkbox"/> Glasses        |
| <input type="checkbox"/> Eye Strain           | <input type="checkbox"/> Eye pain                     | <input type="checkbox"/> Poor vision <input type="checkbox"/> Night Blindness |   |
| <input type="checkbox"/> Color Blindness      | <input type="checkbox"/> Cataracts                    | <input type="checkbox"/> Blurred vision                                       | <input type="checkbox"/> Earaches       |
| <input type="checkbox"/> Ringing in ears      | <input type="checkbox"/> Poor hearing                 | <input type="checkbox"/> Spots in front of eyes                               | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Nose bleeds          | <input type="checkbox"/> Recurrent sore throats/colds | <input type="checkbox"/> Grinding teeth                                       | <input type="checkbox"/> Facial pain    |
| <input type="checkbox"/> Sores on lips/tongue | <input type="checkbox"/> Dental problems              | <input type="checkbox"/> Jaw clicks/locks                                     | <input type="checkbox"/> Headaches      |