Name:________________________

Date:________________________

**General Health Status**

Please rate your health:
- o Excellent
- o Good
- o Fair
- o Poor

**Medical/Surgical**

Please check all that apply to you:
- o Arthritis
- o Broken bones/fractures
- o Osteoporosis
- o Blood disorders
- o Circulation/vascular
- o Heart problems
- o High blood pressure
- o Lung problems
- o Stroke
- o Diabetes/High blood pressure
- o Low blood sugar/Hypoglycemia
- o Head injury
- o Multiple sclerosis
- o Muscular dystrophy
- o Parkinson's disease
- o Seizures/epilepsy
- o Allergies
- o Thyroid problems
- o Cancer
- o Infectious disease
- o Kidney problems
- o Ulcers
- o Skin disease
- o Depression
- o Other_____________________

**Family History**

Please indicate relation of person diagnosed:
- o Heart disease______________
- o Hypertension______________
- o Stroke___________________
- o Diabetes_________________
- o Cancer__________________
- o Mental Illness______________
- o Arthritis__________________
- o Osteoporosis______________
- o Other_____________________

**Symptoms**

Please check all symptoms you have experienced in the past year:
- o Chest pain
- o Heart palpitations
- o Cough
- o Hoarseness
- o Shortness of breath
- o Dizziness or blackouts
- o Coordination problems
- o Weakness in arms/legs
- o Loss of balance
- o Difficulty walking
- o Joint pain or swelling
- o Pain at night
- o Difficulty sleeping
- o Loss of appetite
- o Nausea/vomiting
- o Difficulty swallowing
- o Bowel problems
- o Weight loss/gain
- o Urinary problems
- o Fever/chills/sweats
- o Headaches
- o Hearing problems
- o Vision problems
- o Other______________

**Medications**

Prescription medications?

Yes____________ No___________

If yes, please list:_______________
______________________________
______________________________

Non-prescribed medications?

Yes____________ No____________

If yes, please list:_______________
______________________________
______________________________

**Surgical Procedures**

Have you ever had surgery?

Yes____________ No____________

Please describe and include date:

| Month/Year | Type |
|---|---|
| _______________ | ___________ |
| _______________ | ___________ |
| _______________ | ___________ |

**For men only:**

Have you been diagnosed with prostate disease? Yes_______ No________

**For women only:**

Have you been diagnosed with;
- o Pelvic inflammatory disease
- o Endometriosis
- o Menstrual problems
- o Complicated pregnancies
- o Could you be pregnant now?
- o Other_____________________

______________________________