

HEALTH HISTORY

Please answer the following questions as thoroughly as possible.

Name: _____ Date: _____

Have you ever been diagnosed with the following conditions?

Please indicate the location(s) of your pain on the body diagram:

- | | | | | |
|---------------------------|--------------------------|-----|--------------------------|----|
| Allergies | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Anemia | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Arthritic conditions | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Cancer or tumors | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Changes in bowel/bladder | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Chemical dependency | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Circulatory problems | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Depression | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Diabetes | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Dizziness | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Emphysema | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Epilepsy | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Frequent urination | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Headaches | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Heart problems | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Hepatitis | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| High blood pressure | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Increase in hunger/thirst | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Internal organ problems | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Menstruation problems | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Multiple Sclerosis | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Nausea or vomiting | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Osteoporosis | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Rheumatoid arthritis | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Sleep Problems | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Stroke | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Thyroid problems | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Tuberculosis | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Unusual fatigue/weakness | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Weight gain/loss | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Are you pregnant? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Do you smoke? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

