Patient Name: _____ Date: _____

PERSONAL AND FAMILY HISTORY:

FAMILY HEALTH HISTORY: **Page 2**

RELATIONSHIP: PAST AND PRESENT HEALTH PROBLEMS:

Mother:_____

Father:_____

Sibling: _____

Grandparent: _____

YOUR MEDICAL CONDITIONS: (Please Check all that apply to **you** alone):

CANCER:

___ Type: _____

CARDIOVASCULAR:
___Arrhythmia
___Tachycardia
___Atrial Fibrillation
___By Pass Surgery
___Heart Attack
___High Blood Pressure
___Pacemaker
___Other cardiovascular problems

EARS, NOSE, THROAT
___Sinus Problems
___Hearing Loss: Right Left
___TMJ Disorder
___Other ears/nose/throat prob.

RESPIRATORY
___Asthma
___Chronic bronchitis
___cough
___COPD
___Emphysema
___Sleep Apnea
___Other respiratory conditions

GASTROINTESTINAL:
___Acid Reflux
___Constipation
___Diarrhea
___Irritable Bowel Syndrome
___Other gastrointestinal problems

GENITOURINARY:
___Bladder suspension
___Inter. Stim for the Bladder
___Kidney disease
___Kidney Stones
___UTI
___other Genitourinary problems

MUSCULOSKELETAL:
___Ankylosing Spondylitis
___Bursitis
___Carpal Tunnel Syndrome
___Fibromyalgia
___Osteoarthritis
___Rheumatoid Arthritis
___Scoliosis
___Other musculoskeletal problems

INTEGUMENTARY (SKIN):
___Psoriasis
___Skin cancer
___Other skin problems

NEUROLOGICAL:
___Stroke
___TIA
___Headaches
___Migraines
___Dizziness
___Vertigo
___Epilepsy/seizures
___Multiple Sclerosis
___Other neurological problems

ENDOCRINE:
___Diabetes
___Pre-diab.
___Hypoglycemia
___Hyperthyroidism
___Hypothyroidism
___Other endocrine

IMMUNOLOGIC:
___Lupus
___HIV
___Aids
___Other immunologic

EYES:
___Cataract
___Glaucoma
___Wear: glasses
contacs
___Other eye problems

OTHER:
___Anxiety
___Dementia
___Depression
___Frequent Falls

Any other illnesses:___
_____
_____

I have reviewed the above medical conditions and nothing applies to me: ☐

Patient Signature: _____