HEALTH HISTORY

Place a mark on "yes" or "no" to indicate if you have had any of the following, also, the date your problem began. Also place a mark to indicate if a blood relative has had any of the following problems.

					Start Date:
Acne	Yes	?	No	?	_____
AIDS	Yes	?	No	?	_____
Alcoholism	Yes	?	No	?	_____
Allergies	Yes	?	No	?	_____
Anemia-Sickle Cell	Yes	?	No	?	_____
Anemia – other	Yes	?	No	?	_____
Arthritis, degenerative	Yes	?	No	?	_____
Or Osteoarthritis	Yes	?	No	?	_____
Artificial Joints	Yes	?	No	?	_____
Artificial Heart Valve	Yes	?	No	?	_____
Asthma	Yes	?	No	?	_____
Bladder infection (cystitis)	Yes	?	No	?	_____
Bleeding disorder	Yes	?	No	?	_____
Bronchitis	Yes	?	No	?	_____
CANCER, Breast	Yes	?	No	?	_____
Cervix	Yes	?	No	?	_____
Colon	Yes	?	No	?	_____
Lung	Yes	?	No	?	_____
Uterus	Yes	?	No	?	_____
Prostate	Yes	?	No	?	_____
Other cancer	Yes	?	No	?	_____
Cirrhosis	Yes	?	No	?	_____
Colitis, spastic	Yes	?	No	?	_____
Ulcerative	Yes	?	No	?	_____
Birth defect	Yes	?	No	?	_____
Diabetes	Yes	?	No	?	_____
Diabetes, uncontrolled	Yes	?	No	?	_____
Emphysema	Yes	?	No	?	_____
Epilepsy	Yes	?	No	?	_____
Glasses or contacts	Yes	?	No	?	_____
Visual problemsList: _____					
Retinal detachment	Yes	?	No	?	_____
Fibrocystic breasts	Yes	?	No	?	_____
Gallbladder problem	Yes	?	No	?	_____
Gout	Yes	?	No	?	_____
Hearing loss, left ear	Yes	?	No	?	_____
Hearing loss, right ear	Yes	?	No	?	_____
High blood fats					
Cholesterol	Yes	?	No	?	_____
Triglycerides	Yes	?	No	?	_____
Heart attack	Yes	?	No	?	_____
Coronary disease	Yes	?	No	?	_____
Rheumatic heart	Yes	?	No	?	_____
Heart valve problem	Yes	?	No	?	_____
Heart murmur	Yes	?	No	?	_____
Enlarged heart	Yes	?	No	?	_____
Heart rhythm problem	Yes	?	No	?	_____
Other heart problem	Yes	?	No	?	_____
Hemorrhoids	Yes	?	No	?	_____
Hepatitis	Yes	?	No	?	_____
Herpes, fever blisters, shingles, genital	Yes	?	No	?	_____
Hiatal hernia	Yes	?	No	?	_____
High blood pressure	Yes	?	No	?	_____
Hypoglycemia low blood sugar	Yes	?	No	?	_____
Infectious mono	Yes	?	No	?	_____
Kidney infection pyelonephritis	Yes	?	No	?	_____
Kidney problem, other	Yes	?	No	?	_____
Knee injury	Yes	?	No	?	_____
Mental illness	Yes	?	No	?	_____
Migraine headache	Yes	?	No	?	_____
Neck strain	Yes	?	No	?	_____
Nervous stomach	Yes	?	No	?	_____
Obesity, more than 20 lbs overweight	Yes	?	No	?	_____
Ovarian cyst	Yes	?	No	?	_____
Pelvic infection	Yes	?	No	?	_____
Peptic ulcer, gastric, duodenal	Yes	?	No	?	_____
Phlebitis	Yes	?	No	?	_____
Pneumonia	Yes	?	No	?	_____
Polyps in colon	Yes	?	No	?	_____
Rheumatic fever	Yes	?	No	?	_____
Rheumatoid arthritis	Yes	?	No	?	_____
Serious injury with permanent damage	Yes	?	No	?	_____
Sinusitis	Yes	?	No	?	_____
Stroke	Yes	?	No	?	_____
Thyroid, overactive	Yes	?	No	?	_____
Thyroid, underactive	Yes	?	No	?	_____
Tuberculosis	Yes	?	No	?	_____
Other problems Not listed					_____

FAMILY HISTORY:

Has anyone in your immediate family, Mother (M), Father (F), Sister (S), Brother (B) had any of the following diseases or disorders. Please indicate which family member/members by M, F, S, B, if applicable

Heart Disease: _____

Blood Disorder: _____

Respiratory for example COPD , Asthma:_____

Diabetes: _____

Cancer: _____

Colon Polyps: _____

Kidney Disease: _____

Hypertension: _____

Thyroid: _____

Depression: _____

Mental Illness: _____

Drug or Alcohol abuse: _____

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