



Please check any conditions you have or have had in the past:

- HIV+  
Date diagnosed: \_\_\_\_\_
- Hepatitis B/Hepatitis C
- Cancer
- Diabetes
- Genetic Disorder: \_\_\_\_\_

- Anxiety
- Depression
- Difficulty in focusing
- Dizziness
- Easily startled
- Excessive worry
- Excessive anger
- Excessive fear
- Fatigue/tiredness
- Headaches
- Loss of sleep/poor sleep
- Loss or gain of weight
- Nervousness/irritability
- Overwhelmed by life

Addiction

**SKIN**

- Boils
- Bruise easily
- Dry skin
- Itching/rash
- Sensitive skin
- Sores won't heal
- Sweats

**MUSCLE/JOINT/  
BONES/TENDONS**

- Tremors or Cramps
- Swollen joints
- Pain
- Weakness
- Numbness
- Arthritis
- Hernia \_\_\_\_\_

**GENITO/URINARY**

- Blood/pus in urine
- Frequent urination
- Inability to control urine
- Kidney infection/stones
- Lowered libido

**CARDIOVASCULAR/  
BLOOD**

- Chest pain
- Hardening of arteries
- Elevated cholesterol/lipids
- High or Low blood pressure
- Pain over heart
- Poor circulation
- Cold hands and feet
- Previous heart attack
- Rapid/irregular heart beat
- Swelling of ankles
- Anemia

Bleeding disorders

Blood clots

**REPRODUCTIVE**

- Erectile difficulty
- Premature ejaculation
- Prostate disease
- Inability to conceive
- Bleeding between periods
- Clots in menses
- Excessive menstrual flow
- Extreme menstrual pain
- Irregular cycle
- Menopausal symptoms
- PMS
- Previous miscarriage
- Scanty menstrual flow
- Breast lump

**EYES/EARS/NOSE/  
THROAT/  
RESPIRATORY**

- Asthma/wheezing
- Blurred or failing vision
- Difficulty breathing
- Earache
- Enlarged glands
- Eye pain
- Frequent colds
- Hay fever/environmental allergies
- Gum trouble
- Nose bleeds
- Loss of hearing
- Persistent cough
- Ringing in ears
- Sinus problems
- Allergies

**GASTROINTESTINAL**

- Belching, gas or bloating
- Food sensitivities
- Diverticulosis/Diverticulitis
- Constipation
- Diarrhea
- Difficulty swallowing
- Distention of abdomen
- Excessive hunger
- Gall bladder trouble
- Hemorrhoids
- Indigestion
- Nausea
- Pain over stomach
- Poor appetite
- Vomiting

Could you be pregnant?  Yes  No

How long has it been since you had a complete medical exam? \_\_\_\_\_

Current Medications: Please list all prescription medications, over-the-counter medications, vitamins, herbs and nutritional supplements you use. Attach additional pages if necessary.

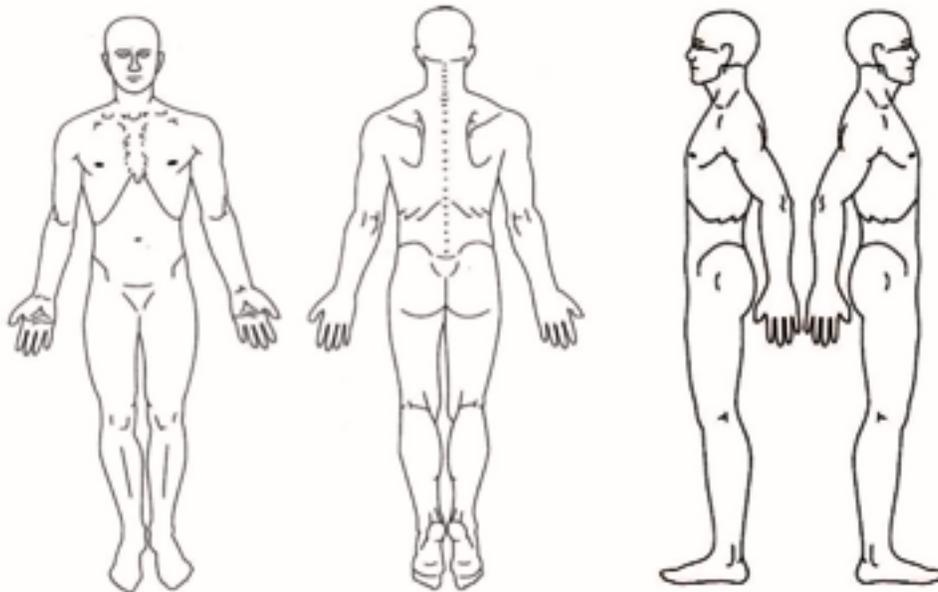
Substance	Dose and Frequency	Start date	Reason for Taking

Please list any hospitalizations or surgeries with dates: \_\_\_\_\_

Check conditions that have occurred in blood relatives:

- Diabetes    High Cholesterol    Stroke    High Blood Pressure  
 Cancer, kind: \_\_\_\_\_    Heart Disease    Mental Illness    Kidney Disease  
 Other relevant family history: \_\_\_\_\_

Please circle below areas where you have:  
Pain, Burning, Numbness, Tingling, Cramping, Weakness



Signature of Patient or Representative: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_