



Name: _____ Date: _____

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present	Past	Present		
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
			<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Wrist Pain						
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Depression
			<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Drug/Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	Hip/Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/>	Knee/Lower Leg Pain	<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis/Eczema
			<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain				<input type="checkbox"/>	<input type="checkbox"/>	Smoking
						<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight gain/loss
<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia			Females Only
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Profuse Menstrual Flow
<input type="checkbox"/>	<input type="checkbox"/>	General Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Breast Soreness/Lumps
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	PMS
<input type="checkbox"/>	<input type="checkbox"/>	Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Pills
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Hormonal Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Colon	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus						
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	Height: _____		
<input type="checkbox"/>	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Liver/Gall Bladder Disorder	Weight: _____		

Indicate if an immediate family member has had any of the following:

- | | | | | |
|--|---|--|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Chronic Back Problems | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other |

Do you have a permanent disability rating? Yes No Rating % _____
 Date Rating Received ____/____/____

Describe your disability _____

List all prescription and over-the-counter medications you are taking: _____

List all the surgical procedures you have had and times you have been hospitalized:

Patient Signature: _____ **Date:** _____