MEDICAL HISTORY

Do you currently, or have you ever had any problems in the following areas? CIRCLE YES OR NO.

PLEASE LIST ALL MEDICATIONS BELOW

Condition	Yes / No	Medications
Vascular / Cardiovascular:...............	Yes No	______
diabetes..............................	Yes No	______
high Blood Pressure...........	Yes No	______
heart Disease.....................	Yes No	______
Respiratory:................................	Yes No	______
asthma..............................	Yes No	______
emphysema........................	Yes No	______
Bones / Joints / Muscles:................	Yes No	______
arthritis..............................	Yes No	______
muscle Pain........................	Yes No	______
Lymphatic / Hematologic:..............	Yes No	______
anemia...............................	Yes No	______
bleeding Problems...............	Yes No	______
Endocrine:....................................	Yes No	______
thyroid problems.................	Yes No	______
Ears, Nose, Throat, Mouth:............	Yes No	______
allergies	Yes No	______
sinus problems......................	Yes No	______
dry mouth(Sjogrens disease)..	Yes No	______
Neurological:................................	Yes No	______
headaches...........................	Yes No	______
seizures.............................	Yes No	______
Gastrointestinal:............................	Yes No	______
diarrhea (Chrones Disease)..	Yes No	______
constipation.......................	Yes No	______
Integumental:...............................	Yes No	______
skin problems.....................	Yes No	______
Constitutional:..............................	Yes No	______
weight loss / weight gain......	Yes No	______
fever................................	Yes No	______
Genitourinary:...............................	Yes No	______
kidney...............................	Yes No	______
bladder..............................	Yes No	______
Allergic / Immunologic:..................	Yes No	______
Psychiatric:..................................	Yes No	______
depression..........................	Yes No	______
behavioral preblems.............	Yes No	______
Social History:		
alcohol use..........................	Yes No	______
tobacco use..........................	Yes No	______

Please list any other medical conditions or medications not covered by the above list: ______

______

SIGNATURE: ______