Past/Present
Medical History

Past	Present	
☐	☐	Headache
☐	☐	Neck Pain
☐	☐	Upper Back Pain
☐	☐	Mid Back Pain
☐	☐	Low Back Pain
☐	☐	Shoulder Pain
☐	☐	Elbow/Upper Arm Pain
☐	☐	Wrist Pain
☐	☐	Hand Pain
☐	☐	Upper Leg Pain
☐	☐	Knee Pain
☐	☐	Ankle/Foot Pain
☐	☐	Jaw Pain
☐	☐	Joint Pain Stiffness
☐	☐	Arthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Asthma
☐	☐	Chronic Sinusitis
☐	☐	Other:_____

Past	Present	Females Only
☐	☐	Birth Control Pills
☐	☐	Hormonal Replacements
☐	☐	Pregnancy

Past	Present	
☐	☐	High Blood Pressure
☐	☐	Heart Attack
☐	☐	Chest Pains
☐	☐	Stroke
☐	☐	Angina
☐	☐	Kidney Stones
☐	☐	Kidney Disorders
☐	☐	Bladder Infection
☐	☐	Painful Urination
☐	☐	Incontinent
☐	☐	Prostate Problems
☐	☐	Abnormal Weight Gain/Loss
☐	☐	Loss of Appetite
☐	☐	Abdominal Pain
☐	☐	Ulcer
☐	☐	Liver/Gall Bladder Disorder
☐	☐	Generalk Fatigue
☐	☐	Muscular incoordination
☐	☐	Visual Disturbances
☐	☐	Dizziness
☐	☐	Diabetes
☐	☐	Excessive Thirst
☐	☐	Frequent Urination
☐	☐	Smoking/Tobacco Use
☐	☐	Drug/ Alcohol Dependence
☐	☐	Allergies
☐	☐	Depression
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Dermatitus/ Eczema/ Rash
☐	☐	HIV/AIDS

Please list prescription medications you are currently taking:_____
_____

Please list all over-the -counter medications you are currently taking:_____
_____

Please list all surgical procedures you have had:_____
_____