

PATIENT MEDICAL HISTORY

Name: _____ Age: _____
Occupation: _____ Work Status: _____

Please check the following conditions as they apply to you:

<u>CONDITIONS</u>	<u>YES</u>	<u>NO</u>	<u>EXPLANATION</u>
Allergies			
Heart Disease			
High Blood Pressure			
Diabetes			
TB			
Hepatitis			
Rheumatoid Arthritis			
Cancer			
Pacemaker			
Stroke			
Severe Dizziness			
Kidney Disorders			
Blood Disorders			
Osteoporosis			
Deep Vein Thrombosis			
Fibromyalgia			
Chronic Fatigue Syndrome			
Gastrointestinal			
Weight loss or gain			
Difficulty swallowing			
Thyroid disorder			
Eating disorder			
Lupus			
Psoriatic arthritis			
Ankylosing spondylitis			
Seizures			
Multiple sclerosis			
Traumatic head or brain injury			
sleep dysfunction: insomnia			

