Medical History Questionnaire

Please list any medication you are currently taking: _____

_____

Please indicate if you have ever had, or currently have, any of the following medical conditions:

CONSTITUTION
☐ Developmental Disabilities
☐ Cancer
☐ Fatigue Syndrome
☐ Other:

_____

EAR NOSE THROAT
☐ Hearing Loss
☐ Sinusitis
☐ Dry Mouth
☐ Laryngitis
☐ Other:

_____

NEUROLOGICAL
☐ Multiple Sclerosis
☐ Epilepsy
☐ Cerebral Palsy
☐ Tumor
☐ Stroke/CVA
☐ Migraine
☐ Autism Spectrum Disorder
☐ Other:

_____

PSYCHIATRIC
☐ Depression
☐ Attention Deficit
☐ Anxiety Disorder
☐ Bipolar Disorder
☐ Other:

_____

CARDIOVASCULAR
☐ Hypertension/High Blood Pressure
☐ Stroke/CVA
☐ Heart Disease
☐ Vascular Disease
☐ Congestive Heart Failure
☐ Other:

RESPIRATORY
☐ Cigarette Smoker
☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Chronic Obstruction
☐ Sleep Apnea
☐ Other:

_____

GASTROINTESTINAL
☐ Crohn's
☐ Colitis
☐ Ulcer
☐ Acid Reflux
☐ Celiac Disease
☐ Other:

_____

GENITOURINARY
☐ Kidney Disease
☐ Prostate Disease/Cancer
☐ STD – Herpetic/Chlamydia
☐ Benign Prostate Hypertrophy
☐ Pregnant (current only)
☐ Nursing (current only)
☐ Herpes
☐ Chlamydia
☐ Other:

_____

MUSCULOSKELETAL
☐ Arthritis
☐ Osteoarthritis
☐ Fibromyalgia
☐ Muscular Dystrophy
☐ Ankylosing Spondylitis
☐ Osteoporosis
☐ Gout
☐ Other:

_____

INTEGUMENTARY
☐ Eczema
☐ Rosacea
☐ Psoriasis
☐ Herpes Simplex/Cold Sores
☐ Herps Zoster/Shingles
☐ Other:

_____

ENDOCRINE
☐ Type 2 Diabetes
☐ Type 1 Diabetes
☐ Thyroid Dysfunction
☐ Hormonal Dysfunction
☐ Other:

_____

HEMATOLOGIC/LYMPHATIC
☐ Anemia
☐ Large-volume Blood Loss
☐ Ulcer
☐ Hypercholesteremia/High Cholesterol
☐ Other:

_____

ALLERGIC/IMMUNE
☐ Drug Allergies
☐ Environmental Allergies
☐ Rheumatoid Arthritis
☐ Lupus
☐ Sjogren's Syndrome
☐ Other:

_____

Date: _____ Signature: _____

Race:

☐ Decline
☐ Unknown
☐ African American
☐ American Indian
☐ Arab
☐ Asian
☐ Caucasian
☐ Hawaiian
☐ Hispanic/Latino
☐ Indian
☐ Multiracial