



Last Name: _____

First Name: _____

Date: _____

Please shade in all circles completely

Past Medical History

- Hypertension Yes No
- Stroke Yes No
- Diabetes Mellitus Yes No
- Atrial fibrillation Yes No
- Fibromyalgia Yes No
- Neuropathy Yes No
- Epilepsy Yes No
- Lyme disease Yes No
- Back surgery Yes No

Current Social History

- smoking Yes No
- alcohol Yes No
- caffeine Yes No
- working Yes No

Psychology

- Depression Yes No
- Tension/stress Yes No
- Sleep disturbances Yes No
- Anxiety Yes No

Musculoskeletal

- Neck pain Yes No
- Back pain Yes No
- Muscle cramping Yes No

General

- Fatigue Yes No
- Lightheadedness Yes No
- Imbalance Yes No
- Vertigo (spinning) Yes No

ENT/respiratory

- Ringing in ears Yes No
- Sinus problems Yes No

Cardiology

- Chest pain Yes No
- Palpitations Yes No

Gastroenterology

- Diarrhea Yes No
- Constipation Yes No
- Nausea Yes No
- Bloating after meals Yes No

Neurology

- Headache Yes No
- Tingling numbness Yes No
- Memory problems Yes No
- Tremors Yes No
- Disorientation Yes No

Ophthalmology

- Blurring of vision Yes No

Hematology

- Easy bruising Yes No

Dermatology

- Rash Yes No