

## Personal Medical History

### *Significant Illnesses*

- |                                     |   |  |  |
|-------------------------------------|---|--|--|
| <input type="checkbox"/> Cancer     | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Hepatitis  | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Stroke          |
| <input type="checkbox"/> HIV (AIDS) | <input type="checkbox"/> Weight Problem | <input type="checkbox"/> Venereal Disease    | <input type="checkbox"/> Mental illness  |
| <input type="checkbox"/> Allergies  | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Addictive Disorders | <input type="checkbox"/> Other: _____    |
| <input type="checkbox"/> Asthma .   | <input type="checkbox"/> Herpes         | <input type="checkbox"/> High Blood Pressure |  |

Please check  if you have experienced any of the following in the last 3 months.

### General:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Peculiar Tastes or Smells | <input type="checkbox"/> Sweat Easily       |
| <input type="checkbox"/> Fevers        | <input type="checkbox"/> Insomina           | <input type="checkbox"/> Bleeding                  | <input type="checkbox"/> Change in Appetite |
| <input type="checkbox"/> Fatigue       | <input type="checkbox"/> Strong Thirst      | <input type="checkbox"/> Weight Loss               | <input type="checkbox"/> Night Sweats       |
| <input type="checkbox"/> Tremors'      | <input type="checkbox"/> Poor Balance       | <input type="checkbox"/> Weight Gain               | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> Cravings      | <input type="checkbox"/> Chills             | <input type="checkbox"/> Joint Pain                | <input type="checkbox"/> Emotional Changes  |
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Sudden Energy Drop | <input type="checkbox"/> Hearing Loss              | <input type="checkbox"/> Bruising Easily    |

### Skin & Hair:

- |                                       |   |   |                                    |
|---------------------------------------|---|---|------------------------------------|
| <input type="checkbox"/> Rashes       | <input type="checkbox"/> Itching                | <input type="checkbox"/> Change in Skin Texture | <input type="checkbox"/> Ulcers    |
| <input type="checkbox"/> Eczema       | <input type="checkbox"/> Hair Loss              | <input type="checkbox"/> Dandruff               | <input type="checkbox"/> Acne      |
| <input type="checkbox"/> Recent Moles | <input type="checkbox"/> Change in Hair Texture | <input type="checkbox"/> Hives                  | <input type="checkbox"/> Psoriasis |

### ENT + Head & Eyes:

- |  |   |                                       |   |  |
|--|---|---------------------------------------|---|--|
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Eye Pain       | <input type="checkbox"/> Earaches     | <input type="checkbox"/> Migraine               | <input type="checkbox"/> Recurrent Sore Throat |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Glasses        | <input type="checkbox"/> Glaucoma     | <input type="checkbox"/> Eye Strain             |  |
| <input type="checkbox"/> Gum Problems    | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Poor Vision  | <input type="checkbox"/> Grinding of Teeth      | <input type="checkbox"/> Sores on Lips         |
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Headaches      | <input type="checkbox"/> Cataracts.   | <input type="checkbox"/> Floaters               | <input type="checkbox"/> Mouth Ulcers          |
| <input type="checkbox"/> Facial Pain     | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Concussions  | <input type="checkbox"/> Spots in Front of Eyes | <input type="checkbox"/> Toothache             |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Jaw Click      | <input type="checkbox"/> Poor Hearing | <input type="checkbox"/> Nose Bleeds            |  |

### Respiratory:

- |                                   |   |                                 |  |  |
|-----------------------------------|---|---------------------------------|--|--|
| <input type="checkbox"/> Cough    | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Phlegm | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Painful Breathing |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Bronchitis .   | <input type="checkbox"/> Asthma | <input type="checkbox"/> Easily Winded       |  |

### Cardiovascular:

- |                                      |   |  |   |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Cold Hands or Feet  | <input type="checkbox"/> Low Blood Pressure   |
| <input type="checkbox"/> Phlebitis   | <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Swelling of Hands   | <input type="checkbox"/> Shortness of Breath  |
| <input type="checkbox"/> Chest Pain  | <input type="checkbox"/> Swelling of Feet | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Palpitations     | <input type="checkbox"/> High Blood Pressure |   |

### Gastrointestinal:

- |                                      |                                       |  |   |
|--------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Nausea      | <input type="checkbox"/> Bloating     | <input type="checkbox"/> Blood in Stools | <input type="checkbox"/> Abdominal Pain |
| <input type="checkbox"/> Belching    | <input type="checkbox"/> Constipation | <input type="checkbox"/> Black Stools    | <input type="checkbox"/> Vomiting       |
| <input type="checkbox"/> Diarrhea    | <input type="checkbox"/> Hemorrhoids  | <input type="checkbox"/> Bad Breath      | <input type="checkbox"/> Gastric Ulcers |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Parasites    | <input type="checkbox"/> Intestinal Gas  |   |

### Genito-Urinary:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Painful Urination | <input type="checkbox"/> Urgent Urination | <input type="checkbox"/> Scanty Urination     | <input type="checkbox"/> Frequent Urination       |
| <input type="checkbox"/> Blood in Urine    | <input type="checkbox"/> Impotence        | <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Frequent Night Urination |
| <input type="checkbox"/> Genital Sores     | <input type="checkbox"/> Kidney Stones    | <input type="checkbox"/> Discolored Urine     |   |