PLEASE CHECK "*YES*" TO CONDITIONS YOU ARE CURRENTLY EXPERIENCING

GENERAL YES
1. Fever ☐
2. Chills ☐
3. Weight loss ☐
4. Night sweats ☐
5. Other_____

EARS YES
1. Hearing loss - gradual ☐
2. Hearing loss - sudden ☐
3. Pain ☐
4. Ringing ☐
5. Dizziness or vertigo ☐
6. Frequent infections ☐
7. Other_____

NOSE YES
1. Nose bleeds ☐
2. Injury ☐
3. Congestion ☐
4. Runny nose ☐
5. Mouth breather ☐
6. Other_____

THROAT YES
1. Frequent sore throats ☐
2. Difficulty swallowing ☐
3. Hoarseness ☐
4. Foreign body ☐
5. Thyroid problems ☐
6. Swollen tonsils ☐
7. Other_____

EYES YES
1. Cataracts ☐
2. Glaucoma ☐
3. Distorted vision ☐
4. Other_____

HEART YES
1. High blood pressure ☐
2. Chest pain ☐
3. Irregular heart beat ☐
4. Previous heart attack ☐
5. Other_____

LUNGS YES
1. Bronchitis/chronic cough ☐
2. Asthma/wheezing ☐
3. Congestion ☐
4. Other_____
5.

ALLERGY/ IMMUNE YES
1. Seasonal allergies ☐
2. Itchy eyes ☐
3. Runny Nose ☐
4. Allergy testing in past ☐
5. HIV or AIDS ☐

GASTROINTESTINAL YES
1. Indigestion or Heartburn ☐
2. Ulcers ☐
3. Diarrhea ☐
4. Diverticulitis ☐
5. Gall bladder trouble ☐
6. Nausea & vomiting ☐
7. Other_____

URINARY TRACT YES
1. Kidney problems ☐
2. Painful urination ☐
3. Bloody urination ☐
4. Prostate problems (men) ☐
5. Other_____

MUSCULOSKELETAL YES
1. Back pain ☐
2. Weakness of limbs ☐
3. Arthritis ☐
4. Other_____

NEURO/PYSCH YES
1. Numbness ☐
2. Migraine headaches ☐
3. Seizures ☐
4. Convulsions ☐
5. Stroke ☐
6. Depression ☐
7. Other_____

ENDOCRINE YES
1. Thyroid disorders ☐
2. Diabetes ☐
3. Menopause (women) ☐
4. Hormonal replacement ☐
5. Pregnant (women) ☐

BLOOD DISORDERS YES
1. Low blood counts ☐
2. Free bleeding ☐
3. Blood clots ☐
4. Blood disorders ☐
5. Hepatitis ☐
6. Other_____

Patient Name _____ Date _____

Patient Signature _____