

Please apply check to boxes below: C =currently P =previously N= never

GENERAL SYMPTOMS

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HEADACHE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FEVER
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CHILLS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NIGHT SWEATS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DIZZINESS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CONVULSIONS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LOSS OF SLEEP
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	FATIGUE
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	in extremities
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing

MUSCLE & JOINTS

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Twitching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiff Neck
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bachache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Tailbone
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in btwn
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Curvature

SKIN/ALLERGIES

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin eruptions
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brusing Easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive skin
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis

Have you had any of the following:

<input type="checkbox"/>	Appendicitis
<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Polio
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Measles
<input type="checkbox"/>	Mumps

HABITS

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smoking
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coffee
RESPIRATORY			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting Blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting Phlegm
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing

GASTRO-INTESTINAL

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Digestion
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Hunger
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching/Gas
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over stomach
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver toruble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble

CARDIO-VASCULAR

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prev. Heart trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling ankles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strokes

EYE-EAR-NOSE-THROAT

C P N

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor vision
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain in eyes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Noises
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Obstruction
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble

GENITO-URINARY

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Freq. urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostrate trouble

WOMEN ONLY

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful periods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive flow
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps or Backaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Discharge
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant at this time
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap

<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Mental Disorder
<input type="checkbox"/>	Lumbago
<input type="checkbox"/>	Eczema

Family History/List Member:

Diabetes	_____
Heart	_____
Kidney	_____
Cancer	_____