

Self- Health History

Constitutional Symptoms			Gastrointestinal		
Developmental Disabilities	Yes	No	Celiac Disease	Yes	No
Fatigue Syndrome	Yes	No	Ulcer	Yes	No
Cancer	Yes	No	Acid Reflux	Yes	No
Other:			Crohn's	Yes	No
Ear / Nose/ Mouth / Throat			Colitis	Yes	No
Sinusitis	Yes	No	Other:		
Dry Mouth	Yes	No	Genitourinary		
Laryngitis	Yes	No	Nursing	Yes	No
Hearing Loss	Yes	No	Pregnant	Yes	No
Other:			Benign Prostate Hypertrophy	Yes	No
Neurological			STD	Yes	No
Tumor	Yes	No	Prostate Disease / Cancer	Yes	No
Stroke / CVA	Yes	No	Kidney Disease	Yes	No
Migraine	Yes	No	Herpes	Yes	No
Multiple Sclerosis	Yes	No	Chlamydia	Yes	No
Epilepsy	Yes	No	Other:		
Cerebral Palsy	Yes	No	Musculoskeletal		
Other:			Muscular Dystrophy	Yes	No
Psychiatric			Ankylosing Spondylitis	Yes	No
Bipolar Disorder	Yes	No	Osteoarthritis	Yes	No
Attention Deficit	Yes	No	Fibromyalgia	Yes	No
Anxiety Disorder	Yes	No	Arthritis	Yes	No
Depression	Yes	No	Gout	Yes	No
Other:			Osteoporosis	Yes	No
Cardiovascular			Other:		
Congestive Heart Failure	Yes	No	Integumentary		
Vascular Disease	Yes	No	Eczema	Yes	No
Heart Disease	Yes	No	Psoriasis	Yes	No
Stroke / CVA	Yes	No	Rosacea	Yes	No
Hypertension	Yes	No	Herpes Zoster / Shingles	Yes	No
Other:			Herpes Simplex / Cold Sores	Yes	No
Respiratory			Other:		
Sleep Apnea	Yes	No	Endocrine		
Chronic Obstruction	Yes	No	Thyroid Dysfunction	Yes	No
Asthma	Yes	No	Type 1 Diabetes Mellitus	Yes	No
Cigarette Smoker	Yes	No	Type 2 Diabetes Mellitus	Yes	No
Emphysema	Yes	No	Hormonal Dysfunction	Yes	No
Bronchitis	Yes	No	Other:		
Other:			Allergic / Immune		
Hematological / Lymphatic			Environmental Allergies	Yes	No
Hypercholesteremia	Yes	No	Drug Allergies	Yes	No
Large-Volume Blood Loss	Yes	No	Lupus	Yes	No
Anemia	Yes	No	Rheumatoid Arthritis	Yes	No
Other:			Sjogren's Syndrome	Yes	No
			Other:		

Current Medications (Please Include Any Prescribed and Over the Counter Medications)
 If you have a list of medications, please let us know and we will be happy to make a copy.

Medication Name	For Condition	Date Began