For the following, please check YES for a condition you have currently and PAST for a condition you've had in the past, noting the date in the space provided.

Skin:

Currently Have?	**YES**	**PAST**	**When?**
Acne, Boils	□	□	___________
Acute Hair Loss	□	□	___________
Itching/Rash	□	□	___________
Other___________	□	□	___________

Respiratory System:

Currently Have?	**YES**	**PAST**	**When?**
Chronic Asthma	□	□	___________
Chronic Cough	□	□	___________
Frequent Colds	□	□	___________
Pain in Breathing	□	□	___________
Shortness of Breath	□	□	___________
Sinus Congestion	□	□	___________
Temporary Cough	□	□	___________
Nasal Drainage to Throat	□	□	___________
Other___________	□	□	___________

Head, Ear, Eyes, Nose, Throat:

Currently Have?	**YES**	**PAST**	**When?**
Head:			
Headaches	□	□	___________
Migraines	□	□	___________
Head Injury	□	□	___________
Hay Fever	□	□	___________
Ears:			
Earaches	□	□	___________
Ringing in Ears	□	□	___________
Impaired Hearing	□	□	___________
Dizziness	□	□	___________
Eyes:			
Eye Pain or Strain	□	□	___________
Impaired Vision	□	□	___________
Tearing or Dryness	□	□	___________
Nose:			
Nose Bleeds	□	□	___________
Loss of Smell	□	□	___________
Throat:			
Goiter	□	□	___________
Hoarseness	□	□	___________
Swollen Glands	□	□	___________
Trouble Swallowing	□	□	___________
Neck Pain/Stiffness	□	□	___________
Frequent SoreThroat	□	□	___________
Other___________	□	□	___________

Digestive System:

Currently Have?	**YES**	**PAST**	**When?**
Nausea/vomiting	□	□	___________
Heartburn	□	□	___________
Gas or Bloating	□	□	___________
Internal Cramping	□	□	___________
Constipation	□	□	___________
Diarrhea	□	□	___________
Loose Stool	□	□	___________
Hemorrhoids	□	□	___________
Other___________	□	□	___________

Cardiovascular:

Currently Have?	**YES**	**PAST**	**When?**
Heart Disease	□	□	___________
Chest Pain	□	□	___________
Palpitations or Fluttering	□	□	___________
High Blood Pressure	□	□	___________
Low Blood Pressure	□	□	___________
Blood Clots	□	□	___________
Ankle Swelling	□	□	___________
Fainting	□	□	___________
Other___________	□	□	___________

Urinary Tract:

Currently Have?	**YES**	**PAST**	**When?**
Frequent Infection	□	□	___________
Frequent Urination	□	□	___________
Inability to Hold Urine	□	□	___________
Burning or Pain or Blood During Urination	□	□	___________
Kidney Stones	□	□	___________
Other___________	□	□	___________

Musculoskeletal:

Currently Have?	**YES**	**PAST**	**When?**
Weakness	□	□	___________
Muscle Spasms or Cramps	□	□	___________
Joint Pain, Swelling, or Stiffness	□	□	___________
Sciatica	□	□	___________
Fibromyalgia	□	□	___________
Broken Bones	□	□	___________
Any Other Pain	□	□	___________
Location: ______________________________________			
Other __________	□	□	___________

Other:

Currently Have?	**YES**	**PAST**	**When?**
Thyroid/endocrine disorders	□	□	___________
Diabetes	□	□	___________
Autoimmune disorders	□	□	___________
Other ____			

REPRODUCTIVE, IF APPLICABLE:

Do you now, or have you ever had…?			**When?**
Testicular Masses	□ No	□ Yes	___________
Testicular Pain	□ No	□ Yes	___________
Prostate Trouble	□ No	□ Yes	___________
Erection Difficulties	□ No	□ Yes	___________
Breast Lumps	□ No	□ Yes	___________
Nipple Discharge	□ No	□ Yes	___________
Fibroids or ovarian cysts	□ No	□ Yes	___________
Irregular Cycle	□ No	□ Yes	___________
PMS Symptoms	□ No	□ Yes	___________
Painful Menses	□ No	□ Yes	___________
Clotting during menses	□ No	□ Yes	___________
Bleeding between periods	□ No	□ Yes	___________
Fertility difficulties	□ No	□ Yes	___________
Other ________________	□ No	□ Yes	___________