

**Medical History**

Do you or have you ever had any of the following conditions? If yes, please indicate date of diagnosis.

	<b>Date Diagnosed</b>		<b>Date Diagnosed</b>
Cancer type: _____	_____	HIV	_____
Diabetes	_____	Mental Illness	_____
Heart Disease	_____	Seizures	_____
Hepatitis	_____	Stroke	_____
High Blood Pressure	_____	Thyroid Disease	_____
High Cholesterol	_____	Other _____	_____

Please list any surgeries or major injuries with dates.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any medications or supplements you have taken in the past 2 months.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a pacemaker or any metal devices in your body? **Y / N**

Is there a chance you are pregnant?: **Y / N**

Are you on any blood thinners (Aspirin, Plavix, Coumadin, Warfarin, etc.)?: \_\_\_\_\_

**Family History**

Indicate close family members with any of the following conditions.

	<b>Family Member(s)</b>		<b>Family Member(s)</b>
Cancer (specify type)	_____	High Cholesterol	_____
Diabetes	_____	Mental Illness	_____
Heart Disease	_____	Stroke	_____
High Blood Pressure	_____	Alcoholism	_____

**Lifestyle Habits**

Do you have an exercise routine? Please describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How many hours per night do you sleep on average? \_\_\_\_\_ Do you wake rested? **Y / N**

Nicotine Use: \_\_\_\_\_ Alcohol Use (#drinks/week and type): \_\_\_\_\_

Caffeine Use (#drinks/day and type): \_\_\_\_\_

Water intake (how much/day): \_\_\_\_\_

Briefly describe your dietary habits (#meals/day and type of food): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please check all that apply:**

**Energy and Immunity**

- Fatigue
- Allergies (Specify) \_\_\_\_\_
- Anemia
- Chronic Fatigue Syndrome
- Thyroid Problems
- Tendency to Catch Colds

**Head, Eyes, Ears, Nose and Throat**

- Glasses / Contacts
- Eye Dryness
- Blurry Vision
- Poor Night Vision
- Ear Ringing
- Hearing Difficulties
- Headaches / Migraines
- Teeth Grinding / TMJ
- Sore Throat
- Chronic Sinus Congestion
- Dry Mouth
- Bad Breath
- Mouth Sores / Bleeding Gums
- Increase in Thirst

**Emotions / Sleep**

- Mood Swings
- Anxious / Worried
- Depressed
- Irritable
- Difficulty Making Decisions
- Stressed
- Insomnia
- Nightmares
- Difficulty Falling or Staying Asleep

**Respiratory / Cardiovascular**

- Pacemaker
- High Blood Pressure
- Shortness of Breath
- Asthma
- Chest Pain
- Palpitations / Fluttering
- Poor Circulation (Cold Hands/Feet)
- Chronic Cough
- Night Sweats
- Unusual Sweating
- Hot / Cold Intolerance

**Gastrointestinal**

- Ulcers
- Changes in Appetite
- Nausea / Vomiting
- Bloating / Pain
- Gas
- Heartburn / Acid Reflux
- Belching
- Hemorrhoids
- Diarrhea
- Constipation
- Sudden Weight Change

**Kidney/Urinary**

- Painful Urination
- Frequent Urinary Tract Infections
- Frequent / Urgent Urination
- Edema / Swelling

**Musculoskeletal**

- Neck / Shoulder Pain
- Muscle Spasms / Cramps / Weakness
- Arm Pain
- Finger Pain / Tingling / Numbness
- Upper Back Pain
- Mid Back Pain
- Low Back Pain
- Leg / Knee Pain
- Foot / Ankle Pain
- Hip / Pelvic Pain
- Arthritis

**Neurological**

- Vertigo / Dizziness
- Numbness / Tingling
- Difficulty Concentrating / Poor Memory

**Skin**

- Rashes / Eczema / Hives / Psoriasis
- Dry Hair or Hair Loss
- Changes in Skin Color
- Easy Bruising
- Acne
- Dry / Itchy Skin

**Female Health**

- Irregular Cycle
- Heavy Flow
- Light Flow
- Clots in Menstrual Blood
- Menstrual Related Moodiness
- Menstrual Related Breast Tenderness
- Menstrual Related Bloating
- Bleeding Between Cycles
- Painful Periods (is pain before, during &/or after? \_\_\_\_\_)
- Menopausal
- Hot Flashes
- Vaginal Dryness
- Breast Lumps / Cysts
- Uterine Fibroids
- Endometriosis
- Ovarian Cysts
- Unusual Vaginal Discharge / Odor
- Frequent Yeast Infections
- Decreased Libido

**Male Health**

- Prostate Enlargement
- Impotence
- Premature Ejaculation
- Decreased Libido
- Groin Pain