

### MEDICATIONS

Please list all Medications, Herbs, and Supplements that you take regularly.

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### INJURIES & TRAUMAS (PHYSICAL/EMOTIONAL)

When   What Happened?

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### SURGERIES

When   What Surgery?

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### CHILDHOOD HEALTH HISTORY

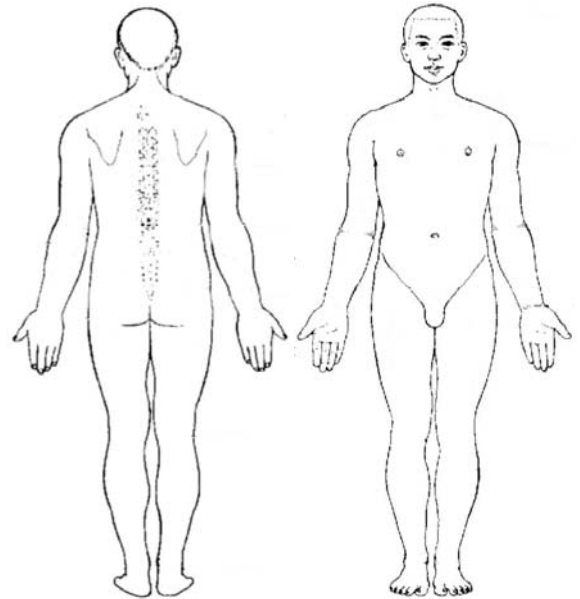
- |                                      |   |  |   |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> Frequent Earaches    | <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Forceps Delivery         |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Frequent Sore Throat | <input type="checkbox"/> Premature Birth | <input type="checkbox"/> Other Birth Trauma _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Frequent Cold / Flu  | <input type="checkbox"/> Prolonged Labor | <input type="checkbox"/> Other _____              |

### MUSCULOSKELETAL/EXTREMITIES

Pain, Weakness, Numbness in:

- |   |                                      |  |
|---|--------------------------------------|--|
| <input type="checkbox"/> Head             | <input type="checkbox"/> Wrists      | <input type="checkbox"/> Legs                |
| <input type="checkbox"/> Neck             | <input type="checkbox"/> Hands       | <input type="checkbox"/> Knees               |
| <input type="checkbox"/> Shoulders        | <input type="checkbox"/> Fingers     | <input type="checkbox"/> Ankles              |
| <input type="checkbox"/> Arms             | <input type="checkbox"/> Back: U/M/L | <input type="checkbox"/> Feet                |
| <input type="checkbox"/> Elbows           | <input type="checkbox"/> Hips        | <input type="checkbox"/> Toes                |
| .....                                     |                                      |  |
| <input type="checkbox"/> Joint Swelling   | <input type="checkbox"/> Edema       | <input type="checkbox"/> Carpal Tunnel       |
| <input type="checkbox"/> Broken Bones     | <input type="checkbox"/> Tendonitis  | <input type="checkbox"/> Sprains/Strains     |
| <input type="checkbox"/> Bone Deformities | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Rotator Cuff        |
| <input type="checkbox"/> Paralysis        | <input type="checkbox"/> Bursitis    | <input type="checkbox"/> Poor Balance        |
| <input type="checkbox"/> Whole Body Pain  | <input type="checkbox"/> Sciatica    | <input type="checkbox"/> Restricted Movement |
| <input type="checkbox"/> Other _____      |                                      |  |

Please Mark All Places on the Body Where You Have Any Concern →



### HEAD, EYES, EARS, NOSE, THROAT

- |  |  |   |   |  |
|--|--|---|---|--|
| <input type="checkbox"/> Migraines       | <input type="checkbox"/> Eye Strain      | <input type="checkbox"/> Poor Hearing   | <input type="checkbox"/> Sinus Problems   | <input type="checkbox"/> Dry Lips/Mouth        |
| <input type="checkbox"/> Poor Vision     | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Earaches       | <input type="checkbox"/> Sore Throats     | <input type="checkbox"/> Dry Throat            |
| <input type="checkbox"/> Blurry Vision   | <input type="checkbox"/> Eye Pain        | <input type="checkbox"/> Ear Ringing    | <input type="checkbox"/> Lip/Mouth Sores  | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Cataracts       | <input type="checkbox"/> Excess Ear Wax | <input type="checkbox"/> Tongue Sores     | <input type="checkbox"/> Headaches             |
| <input type="checkbox"/> Glasses         | <input type="checkbox"/> Red/Itchy Eyes  | <input type="checkbox"/> Nose Bleeds    | <input type="checkbox"/> Grinding Teeth   | <input type="checkbox"/> Heavy-headed          |
| <input type="checkbox"/> Spots in Eyes   | <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Poor Smell     | <input type="checkbox"/> Jaw locks/clicks | <input type="checkbox"/> Light-headed          |

### CARDIOVASCULAR

- |  |  |   |  |  |
|--|--|---|--|--|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Irregular Heart Beats | <input type="checkbox"/> Blood Clots          | <input type="checkbox"/> Bleed/Bruise Easily | <input type="checkbox"/> Phlebitis           |
| <input type="checkbox"/> Slow Heart Rate     | <input type="checkbox"/> Palpitations          | <input type="checkbox"/> Spontaneous Sweating | <input type="checkbox"/> Chest Pain/Pressure | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Fast Heart Rate     | <input type="checkbox"/> Varicose/Spider Veins | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Hands/Feet Swelling | <input type="checkbox"/> Low Blood Pressure  |

### RESPIRATORY

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Cough/Wheezing  | <input type="checkbox"/> Pneumonia      | <input type="checkbox"/> Difficult Inhale/Exhale | <input type="checkbox"/> Bronchitis                           |
| <input type="checkbox"/> Frequent Colds  | <input type="checkbox"/> Coughing Blood | <input type="checkbox"/> Pain on Deep Inhalation | <input type="checkbox"/> Phlegm (color: _____)                |
| <input type="checkbox"/> Frequent Fevers | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Chest Tightness         | <input type="checkbox"/> Difficulty Breathing when lying down |