MEDICAL HISTORY QUESTIONNAIRE

Please list any medications you are currently taking: _____

_____

Please indicate if you have ever had, or currently have, any of the following medical conditions.

CONSTITUTION
- ☐ Developmental Disabilities
- ☐ Fatigue Syndrome
- ☐ Cancer
- ☐ Other: _____

EARS NOSE THROAT
- ☐ Hearing Loss
- ☐ Laryngitis
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Other: _____

NEUROLOGICAL
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Stroke/CVA
- ☐ Multiple Sclerosis
- ☐ Migraine
- ☐ Tumor
- ☐ Other: _____

PSYCHIATRIC
- ☐ Attention Deficit
- ☐ Bipolar Disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Other: _____

CARDIOVASCULAR
- ☐ Heart Disease
- ☐ High Blood Pressure (Hypertension)
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Other: _____

RESPIRATORY
- ☐ Sleep Apnea
- ☐ Emphysema
- ☐ Asthma
- ☐ Chronic Obstruction
- ☐ Bronchitis
- ☐ Other: _____

GASTROINTESTINAL
- ☐ Ulcer
- ☐ Celiac Disease
- ☐ Colitis
- ☐ Crohn's
- ☐ Acid Reflux
- ☐ Other: _____

GENITOURINARY
- ☐ Herpes
- ☐ Pregnant
- ☐ Nursing
- ☐ Prostate Disease/Cancer
- ☐ Chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Kidney Disease
- ☐ Other: _____

MUSCULOSKELETAL
- ☐ Arthritis
- ☐ Gout
- ☐ Ankylosing Spondylitis
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Muscular Dystrophy
- ☐ Other: _____

INTEGUMENTARY
- ☐ Herpes Zoster (Shingles)
- ☐ Herpes Simplex (Cold Sores)
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Eczema
- ☐ Other: _____

ENDOCRINE
- ☐ Hormonal Dysfunction
- ☐ Thyroid Dysfunction
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Other: _____

HEMOTOLOGIC/LYMPHATIC
- ☐ Large-volume Blood Loss
- ☐ Anemia
- ☐ High Cholesterol (Hypercholesteremia)
- ☐ Other: _____

ALLERGIC/IMMUNE
- ☐ Rheumatoid Arthritis
- ☐ Sjogren's Syndrome
- ☐ Lupus
- ☐ Other: _____

Date: _____ **Signature:** _____