

Indicate if you have any immediate family members with any of the following:

- ☐ **Rheumatoid Arthritis**
☐ **Diabetes**
☐ **Lupus**
☐ **Heart Problems**
☐ **Cancer**  
☐ **ALS**

For each of the conditions listed below, place a check in the “past” column if you have had the condition in the past. If you presently have a condition listed below, place a check in the “present” column.

<b>Past</b>	<b>Present</b>	<b>Past</b>	<b>Present</b>	<b>Past</b>	<b>Present</b>
<input type="checkbox"/>	<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/> Diabetes
<input type="checkbox"/>	<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/> Heart Attack	<input type="checkbox"/>	<input type="checkbox"/> Excessive Thirst
<input type="checkbox"/>	<input type="checkbox"/> Upper Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Chest Pains	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/> Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Stroke	<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain
<b>Use</b>					
<input type="checkbox"/>	<input type="checkbox"/> Smoking/Tobacco	<input type="checkbox"/>	<input type="checkbox"/> Drug/Alcohol Dependence		
<input type="checkbox"/>	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/> Angina	<input type="checkbox"/>	<input type="checkbox"/> Allergies
<input type="checkbox"/>	<input type="checkbox"/> Elbow/Upper Arm Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/> Depression
<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/>	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/>	<input type="checkbox"/> Hand Pain	<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/> Painful Urination	<input type="checkbox"/>	<input type="checkbox"/> Dermatitis/Eczema/Rash
<input type="checkbox"/>	<input type="checkbox"/> Upper Leg Pain	<input type="checkbox"/>	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/> Abnormal Weight Gain/Loss
<input type="checkbox"/>	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/>	<input type="checkbox"/> Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/> Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/> Joint Pain/Stiffness	<input type="checkbox"/>	<input type="checkbox"/> Ulcer
<input type="checkbox"/>	<input type="checkbox"/> Arthritis	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/> Cancer	<input type="checkbox"/>	<input type="checkbox"/> Liver/Gallbladder Disorder	<input type="checkbox"/>	<input type="checkbox"/> Cancer
<input type="checkbox"/>	<input type="checkbox"/> General Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Tumor	<input type="checkbox"/>	<input type="checkbox"/> Asthma
<input type="checkbox"/>	<input type="checkbox"/> Muscle	<input type="checkbox"/>	<input type="checkbox"/> Visual Disturbances	<input type="checkbox"/>	<input type="checkbox"/> Chronic Sinitus
<input type="checkbox"/>	<input type="checkbox"/> In coordination				
<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Other:		
<b>Females Only</b>					
<input type="checkbox"/>	<input type="checkbox"/> Birth Control	<input type="checkbox"/>	<input type="checkbox"/> Hormonal	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy

Patient Signature\_\_\_\_\_

Date:\_\_\_\_\_