

If you have ever had a listed symptom in the past; please check that symptom in the *Past* column. If you are presently troubled by a particular symptom, check that symptom in the *Present* column.

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Pain
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Arm or Elbow
<input type="checkbox"/>	<input type="checkbox"/>	Hand Pain
<input type="checkbox"/>	<input type="checkbox"/>	Upper Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Low Back Pain
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Upper Leg or Hip
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Lower Leg or Knee
<input type="checkbox"/>	<input type="checkbox"/>	Pain in Ankle or Foot
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of Joints (Specify Joints) _____
<input type="checkbox"/>	<input type="checkbox"/>	Stiffness of Joints (Specify Joints) _____
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Muscular Incoordination
<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus (Ear Ringing)
<input type="checkbox"/>	<input type="checkbox"/>	Rapid Heart Rate
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Gain
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Weight Loss
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	<input type="checkbox"/>	Chronic Sinusitis

Present Weight \_\_\_\_\_ pounds  
 Height \_\_\_\_\_ feet \_\_\_\_\_ inches

Listed below are common disease and disorders. Please indicate whether you have had a particular disorder in the past or are presently troubled by a listed disorder.

Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Aortic Aneurysm
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Angina
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal Symptoms
<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination
<input type="checkbox"/>	<input type="checkbox"/>	Loss of Bladder Control
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in Swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/ Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Rash
<input type="checkbox"/>	<input type="checkbox"/>	Dermatitis or Eczema

Please check an of the following that apply to you.

<input type="checkbox"/>	<input type="checkbox"/>	Tobacco
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol use
<input type="checkbox"/>	<input type="checkbox"/>	Medications (please list) _____
		_____
		_____
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Surgical Procedures (please list) _____
		_____
		_____
<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Caffeinated Soft Drinks cups per day
		_____
YES	NO	Do you have a permanent disability rating?
<input type="checkbox"/>	<input type="checkbox"/>	Location _____
		Date rating received ____ / ____ / ____
		Rating Percentage _____ %

Patient's Signature: \_\_\_\_\_

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

Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema (chronic lung disorders)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Ulcer
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infection
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Other _____
		_____