**Medical Conditions**: (Circle all that apply to you)

| | | | |
|---|---|---|---|
| Arthritis | Cancer | Diabetes | Heart Disease |
| Hypertension | Psychiatric Illness | Skin Disorder | Stroke |
| Osteoporosis | Fibromyalgia | Asthma | Other________ |

**Surgeries**: (Circle all that apply to you)

| | | | |
|---|---|---|---|
| Appendectomy | Cardiovascular procedure | Cervical spine | Hysterectomy |
| Joint Replacement | Prostate | Lumbar spine | Gall Bladder |
| Brain | Shoulder | Thoracic spine | Knee |
| Carpal Tunnel | Gastro-intestinal | Bladder/Kidney | Hernia |
| Breast Augmentation | Wisdom Teeth/Oral | Other _____________ | |

**Allergies**: (Circle all that apply to you)

Mold    Seasonal    Milk or Lactose    Latex    Nuts (All types)

Chemical ___________    Wheat/Glutens    Other _________

**Social History**: (Circle all that apply to you)

| | | | |
|---|---|---|---|
| Caffeine use: | occasional | often | never |
| Drink Alcohol: | occasional | often | never |
| Exercise: | occasional | often | never |
| Cigarettes: | <1 pack/day | >1 pack/day | never |
| Sleep: | 4-6 hours/night | 7-more hours/night | Insomnia |
| Other _______________ | | | |

**Family History**: (Circle all that apply)

| | | |
|---|---|---|
| Arthritis: | Parent | Sibling |
| Cancer: | Parent | Sibling |
| Diabetes: | Parent | Sibling |
| Heart Disease | Parent | Sibling |
| Hypertension | Parent | Sibling |
| Stroke | Parent | Sibling |
| Thyroid | Parent | Sibling |
| Other _________________ | | |

**Patient Name**________________________________________________**Date**__________________