MEDICAL HISTORY

☐ =Past Condition ☐ =Ongoing Condition

Diseases/ Diagnosis/ Conditions *Check appropriate box and provide date of onset*

GASTROINTESTINAL

- ☐ ☐ Irritable Bowel Syndrome _____
- ☐ ☐ Inflammatory Bowel Disease _____
- ☐ ☐ Crohn's _____
- ☐ ☐ Ulcerative Colitis _____
- ☐ ☐ Gastric or Peptic Ulcer Disease _____
- ☐ ☐ GERD (reflux) _____
- ☐ ☐ Celiac Disease _____
- ☐ ☐ Other _____

CARDIOVASCULAR

- ☐ ☐ Heart Attack _____
- ☐ ☐ Other Heart Disease _____
- ☐ ☐ Stroke _____
- ☐ ☐ Elevated Cholesterol _____
- ☐ ☐ Arrythmia (irregular heart rate) _____
- ☐ ☐ Hypertension (high blood pressure) _____
- ☐ ☐ Rheumatic Fever _____
- ☐ ☐ Mitral Valve Prolapse _____
- ☐ ☐ Other _____

METABOLIC/ ENDOCRINE

- ☐ ☐ Type 1 Diabetes _____
- ☐ ☐ Type 2 Diabetes _____
- ☐ ☐ Hypoglycemia _____
- ☐ ☐ Metabolic Syndrome _____
- ☐ ☐ (insulin resistance or pre-diabetes)
- ☐ ☐ Hypothyroidism (low thyroid) _____
- ☐ ☐ Hyperthyroidism (overactive thyroid) _____
- ☐ ☐ Endocrine Problems _____
- ☐ ☐ Polycystic Ovarian Syndrome (PCOS) _____
- ☐ ☐ Infertility _____
- ☐ ☐ Weight Gain _____
- ☐ ☐ Weight Loss _____
- ☐ ☐ Frequent Weight Fluctuations _____
- ☐ ☐ Bulimia _____
- ☐ ☐ Anorexia _____
- ☐ ☐ Binge Eating Disorder _____
- ☐ ☐ Night Eating Syndrome _____
- ☐ ☐ Eating Disorder (non-specific) _____
- ☐ ☐ Other _____

CANCER

- ☐ ☐ Lung Cancer _____
- ☐ ☐ Breast Cancer _____
- ☐ ☐ Colon Cancer _____
- ☐ ☐ Ovarian Cancer _____
- ☐ ☐ Prostate Cancer _____
- ☐ ☐ Skin Cancer _____
- ☐ ☐ Other _____

GENITAL AND URINARY SYSTEMS

- ☐ ☐ Kidney Stones _____
- ☐ ☐ Gout _____
- ☐ ☐ Interstitial Cystitis _____
- ☐ ☐ Frequent Urinary Tract Infections _____
- ☐ ☐ Frequent Yeast infections _____
- ☐ ☐ Erectile Dysfunction _____
- Or sexual Dysfunction _____
- ☐ ☐ Other _____

MUSCULOSKELETAL / PAIN

- ☐ ☐ Osteoarthritis _____
- ☐ ☐ Fibromyalgia _____
- ☐ ☐ Chronic Pain _____
- ☐ ☐ Other _____

INFLAMMATORY/ AUTOIMMUNE

- ☐ ☐ Chronic Fatigue Syndrome _____
- ☐ ☐ Autoimmune Disease _____
- ☐ ☐ Rheumatoid Arthritis _____
- ☐ ☐ Lupus SLE _____
- ☐ ☐ Immune Deficiency Disease _____
- ☐ ☐ Herpes- Genital _____
- ☐ ☐ Severe Infectious Disease _____
- ☐ ☐ Poor Immune Function _____
- (Frequent infections)
- ☐ ☐ Food Allergies _____
- ☐ ☐ Environmental Allergies _____
- ☐ ☐ Multiple Chemical Sensitivities _____
- ☐ ☐ Latex Allergy _____
- ☐ ☐ Other _____

RESPIRATORY DISEASES

- ☐ ☐ Asthma _____
- ☐ ☐ Chronic Sinusitis _____
- ☐ ☐ Bronchitis _____
- ☐ ☐ Emphysema _____
- ☐ ☐ Pneumonia _____
- ☐ ☐ Tuberculosis _____
- ☐ ☐ Sleep Apnea _____
- ☐ ☐ Other _____

SKIN DISEASES

- ☐ ☐ Eczema _____
- ☐ ☐ Psoriasis _____
- ☐ ☐ Acne _____
- ☐ ☐ Melanoma _____
- ☐ ☐ Skin Cancer _____
- ☐ ☐ Other _____

NEUROLOGIC/ MOOD

- ☐ ☐ Depression _____
- ☐ ☐ Anxiety _____
- ☐ ☐ Bipolar Disorder _____
- ☐ ☐ Schizophrenia _____
- ☐ ☐ Headaches _____
- ☐ ☐ ADD/ADHD _____
- ☐ ☐ Autism _____
- ☐ ☐ Mild Cognitive Impairment _____
- ☐ ☐ Memory Problems _____
- ☐ ☐ Parkinson's Disease _____
- ☐ ☐ Multiple Sclerosis _____
- ☐ ☐ ALS _____
- ☐ ☐ Seizures _____
- ☐ ☐ Other _____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam _____
- ☐ Bone Density _____
- ☐ Colonoscopy _____
- ☐ Cardiac Stress Test _____
- ☐ EKG _____
- ☐ Hemoccult Test- stool test for blood _____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____
- ☐ Ultrasound _____
- ☐ X-rays _____

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy _____
- ☐ Hysterectomy +/- Ovaries _____
- ☐ Gall Bladder _____
- ☐ Hernia _____
- ☐ Tonsillectomy _____
- ☐ Dental Surgery _____
- ☐ Joint Replacement – knee/ hip _____
- ☐ Heart Surgery – bypass valve _____
- ☐ Angioplasty or Stent _____
- ☐ Pacemaker _____
- ☐ Other _____
- ☐ None _____

INJURIES

☐ Back Injury ☐ Head Injury ☐ Neck Injury ☐ Broken Bones ☐ Other _____

Do you have any artificial joints or implants? ☐ Yes ☐ No