

Name _____ Date _____

Please CHECK conditions that apply and CIRCLE to specify further as necessary:

| Past | Current | SPECIFY |
|------|---------|---------------------------------------|
| | | Abdominal |
| | | Allergies |
| | | Anxiety |
| | | Arthritis, osteo or rheumatoid |
| | | Asthma |
| | | Bleeding Disorder |
| | | Blood Clots |
| | | Blood Pressure high or low |
| | | Cancer |
| | | Chest Pain |
| | | Chicken Pox/Measles/Mononucleosis |
| | | Cough |
| | | Dental/TMJ |
| | | Depression |
| | | Diabetes |
| | | Digestive Disorder |
| | | Dizziness/Fainting spells |
| | | Ear Disorders/Hearing loss |
| | | Eye Disorders |
| | | Fibromyalgia/Chronic Fatigue |
| | | Genetic Disease |
| | | Gout |
| | | Headaches/Migraines |
| | | Heart Disorder |
| | | Hepatitis |
| | | Hernia |
| | | Kidney Disorder |
| | | Leg cramps |
| | | Low blood sugar |
| | | Lung Disorder |
| | | Lupus |
| | | Malaria |
| | | Nausea/vomiting |
| | | Nose problems/Smell |
| | | Polio, Rheumatic Fever, Scarlet Fever |
| | | Seizures |
| | | Sinus Problems |
| | | Skin Disease |
| | | Spinal problems |
| | | Stroke |
| | | Sudden weight loss/gain |
| | | Thyroid Disease |
| | | Ulcers |
| | | Varicose Veins |
| | | Venereal Disease |
| | | Measles |
| | | Mononucleosis |
| | | Rheumatic Fever |
| | | Scarlet Fever |