



Participant Name/Initial: \_\_\_\_\_ Date: \_\_\_\_\_

CONDITIONS: Check YES or NO column as applicable

Condition	Yes	No	Description/Comment	Start Date	Ongoing	Stop Date
<b>EYES</b>						
Glaucoma					<input type="checkbox"/>	
Vision Disturbance					<input type="checkbox"/>	
Cataracts					<input type="checkbox"/>	
Chronic Infections					<input type="checkbox"/>	
Retinopathy/macular edema					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
<b>NOSE OR THROAT</b>						
Sinus Infections					<input type="checkbox"/>	
Nose Bleeds					<input type="checkbox"/>	
Nasal/Sinus Congestion					<input type="checkbox"/>	
Chronic Throat Infections					<input type="checkbox"/>	
Other					<input type="checkbox"/>	
<b>CARDIOVASCULAR</b>						
High Blood Pressure					<input type="checkbox"/>	
High Cholesterol					<input type="checkbox"/>	
Transient Ischemic Attacks					<input type="checkbox"/>	
Heart Murmur					<input type="checkbox"/>	
Heart Attack (MI)					<input type="checkbox"/>	
Stroke/ CVA					<input type="checkbox"/>	
Peripheral Vascular Disease (PVD)					<input type="checkbox"/>	
Stress Test					<input type="checkbox"/>	
Abdominal ECG					<input type="checkbox"/>	
Angina / Chest Pain					<input type="checkbox"/>	
Carotid Disease					<input type="checkbox"/>	
Congestive Heart Failure					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	

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<b>LUNG/ RESPIRATORY</b>					<input type="checkbox"/>	
Asthma					<input type="checkbox"/>	
Chronic Bronchitis					<input type="checkbox"/>	
Pneumonia					<input type="checkbox"/>	
Chronic Cough					<input type="checkbox"/>	
Emphysema					<input type="checkbox"/>	
Shortness of Breath					<input type="checkbox"/>	
COPD					<input type="checkbox"/>	
Dyspnea on Exertion					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
<b>ENDOCRINE</b>					<input type="checkbox"/>	
Diabetes Type 1 (Insulin Dependent)					<input type="checkbox"/>	
Diabetes Type II					<input type="checkbox"/>	
Hyperthyroidism					<input type="checkbox"/>	
Hypothyroidism					<input type="checkbox"/>	
Goiter					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
<b>GASTROINTESTINAL</b>					<input type="checkbox"/>	
Liver Disease					<input type="checkbox"/>	
Cholecystectomy					<input type="checkbox"/>	
Heartburn					<input type="checkbox"/>	
Irritable Bowel Syndrome					<input type="checkbox"/>	
GERD / Reflux					<input type="checkbox"/>	
Ulcer					<input type="checkbox"/>	
Inflammatory Bowel Disease					<input type="checkbox"/>	
Chronic Constipation					<input type="checkbox"/>	
Chronic Diarrhea					<input type="checkbox"/>	
Blood in Stools					<input type="checkbox"/>	
Hemorrhoids					<input type="checkbox"/>	
Recurrent Abdominal Pain					<input type="checkbox"/>	
Chronic Vomiting					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	

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<b>GENITOURINARY</b>						
Kidney Stone					<input type="checkbox"/>	
Kidney Infection					<input type="checkbox"/>	
Incontinence / Bladder Control Problems					<input type="checkbox"/>	
Bladder Infections					<input type="checkbox"/>	
Enlarged Prostate (BPH)					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
<b>GYNECOLOGICAL</b>						
Sexually Transmitted Disease					<input type="checkbox"/>	
Chronic Vaginal Infections					<input type="checkbox"/>	
Abnormal Mammogram					<input type="checkbox"/>	
Abnormal Pap Smear					<input type="checkbox"/>	
Hot Flashes					<input type="checkbox"/>	
Irregular Menstrual cycle					<input type="checkbox"/>	
Breast lumps / cysts					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
<b>NEUROLOGICAL</b>						
Seizures (type)					<input type="checkbox"/>	
Epilepsy					<input type="checkbox"/>	
Stroke					<input type="checkbox"/>	
Insomnia					<input type="checkbox"/>	
Migraines					<input type="checkbox"/>	
Headaches (type)					<input type="checkbox"/>	
Dizziness / Lightheadedness					<input type="checkbox"/>	
Numbness / Tingling of Extremities					<input type="checkbox"/>	
Paralysis					<input type="checkbox"/>	
Tremors					<input type="checkbox"/>	
Multiple Sclerosis					<input type="checkbox"/>	
Diabetic Neuropathy					<input type="checkbox"/>	
Parkinson's Disease					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	

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<b>MUSCULOSKELETAL</b>						
Osteoarthritis					<input type="checkbox"/>	
Rheumatoid Arthritis					<input type="checkbox"/>	
Osteoporosis					<input type="checkbox"/>	
Fibromyalgia					<input type="checkbox"/>	
Fractures/ Broken Bones					<input type="checkbox"/>	
Leg Cramps					<input type="checkbox"/>	
Recurrent Joint Pain					<input type="checkbox"/>	
Recurrent Back Pain					<input type="checkbox"/>	
Osteopenia					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
<b>SKIN / INTEGUMENTARY</b>					<input type="checkbox"/>	
Acne					<input type="checkbox"/>	
Rosacea						
Atopic Dermatitis						
Cold Sores, Herpes Simplex					<input type="checkbox"/>	
Psoriasis					<input type="checkbox"/>	
Recurrent rashes					<input type="checkbox"/>	
Eczema					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
<b>EMOTIONAL/ PSYCHOLOGICAL</b>						
Drug or Alcohol Abuse					<input type="checkbox"/>	
Depression					<input type="checkbox"/>	
Anxiety/ Panic Attacks					<input type="checkbox"/>	
Psychotic Episodes					<input type="checkbox"/>	
Dementia					<input type="checkbox"/>	
Alzheimer's Disease					<input type="checkbox"/>	
Bi-Polar Disorder					<input type="checkbox"/>	
Schizophrenia					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
<b>IMMUNE SYSTEM</b>						
HIV Positive					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	
<b>BLOOD DISORDER</b>						
Anemia					<input type="checkbox"/>	
Other:					<input type="checkbox"/>	

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<b>CANCER</b>						
Type:					<input type="checkbox"/>	
Type:					<input type="checkbox"/>	
Type:					<input type="checkbox"/>	

**ALLERGIES:** List all including environment, food, dyes, & medication  None

Allergy	Reaction	Date

**SURGERIES/HOSPITALIZATIONS** (√ “S” if surgery, or “H” if hospitalization) List all including Childbirth  
 None

S	H	Date	Reason

**ANESTHESIA:** During any surgery did you experience any complications / reactions to the anesthesia?  
 None

Date	Reaction	Treatment/ Outcome



Participant Name/Initial: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR WOMEN ONLY:** Please complete either Section A or Section B.

Date of last menstrual period: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Section A** -  Able to have children (childbearing potential). Check primary birth control method used.

<input type="checkbox"/>	Oral Contraceptive Pill	<input type="checkbox"/>	Condoms and foam/gel	<input type="checkbox"/>	Vaginal Condom
<input type="checkbox"/>	Contraceptive Injection	<input type="checkbox"/>	Diaphragm and foam/gel	<input type="checkbox"/>	IUD
<input type="checkbox"/>	Contraceptive Implant (Norplant)	<input type="checkbox"/>	Condoms only	<input type="checkbox"/>	None
<input type="checkbox"/>	Partner had vasectomy	<input type="checkbox"/>	Abstinence	<input type="checkbox"/>	Other, type:
<input type="checkbox"/>	Rhythm	<input type="checkbox"/>	Withdrawal	<input type="checkbox"/>	

**Section B** -  Non-childbearing by means of (check one and specify date):

<input type="checkbox"/>	Hysterectomy _____ / _____ / _____
<input type="checkbox"/>	Tubal Ligation (tubes tied) _____ / _____ / _____
<input type="checkbox"/>	Bilateral Oophorectomy _____ / _____ / _____
<input type="checkbox"/>	Natural Post-Menopause: Date of last natural menstrual period _____ / _____ / _____

Additional information/comments:

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by (clinic staff): \_\_\_\_\_ Date: \_\_\_\_\_