Medical History

RA	Diagnosed by Dr. ________________	Date of Diagnosis: _________________	YES NO
LUPUS	Diagnosed by Dr. ________________	Date of Diagnosis: _________________	YES NO
SPLS	Diagnosed by Dr. ________________	Date of Diagnosis: _________________	YES NO
ITP	Diagnosed by Dr. ________________	Date of Diagnosis: _________________	YES NO
SJOGREN'S	Diagnosed by Dr. ________________	Date of Diagnosis: _________________	YES NO
Bone/ Joint	(circle all that apply) Back Neck Jaws Arthritis Pain Knees Feet Hands Fingers Hips		YES NO
Skin Disorders	Psoriasis _______ _______________	Date of Diagnosis: _________________	YES NO

Other (types)____

HEART

Hypertension (high blood pressure)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Congestive Heart Failure (CHF)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Arrhythmia (irregular heart beat)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Heart Attack	Dr. ______________	Date of Diagnosis: _________________	YES NO
Coronary Arteriogram	Dr. ______________	Date of Diagnosis: _________________	YES NO
Angioplasty (balloon dilation)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Pacemaker	Dr. ______________	Date of Diagnosis: _________________	YES NO
Mitral valve prolapse (MPV)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Heart Operation (type)	Dr. ______________	Date of Diagnosis: _________________	YES NO

RESPIRATORY

Lung disorders (type)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Asthma, Emphysema	Dr. ______________	Date of Diagnosis: _________________	YES NO
Nasal disorders (type)	Dr. ______________	Date of Diagnosis: _________________	YES NO

GASTROINTESTINAL

Stomach disorders (type)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Irritable bowel syndrome	Dr. ______________	Date of Diagnosis: _________________	YES NO
Chronic constipation	Dr. ______________	Date of Diagnosis: _________________	YES NO
Diverticulitis or Diverticulosis	Dr. ______________	Date of Diagnosis: _________________	YES NO
Hiatal hernia	Dr. ______________	Date of Diagnosis: _________________	YES NO
Kidney disorders (type)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Liver disorders (type)	Dr. ______________	Date of Diagnosis: _________________	YES NO

ENDOCRINE

Diabetes mellitus (high blood sugar)	Dr. ______________	Date of Diagnosis: _________________	YES NO
High blood cholesterol	Dr. ______________	Date of Diagnosis: _________________	YES NO
High triglycerides	Dr. ______________	Date of Diagnosis: _________________	YES NO
Thyroid disorders	Dr. ______________	Date of Diagnosis: _________________	YES NO

CENTRAL NERVOUS SYSTEM

Seizure – epilepsy (type)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Stroke or paralysis (type)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Tension or migraine headaches (type)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Vision disorders	Dr. ______________	Date of Diagnosis: _________________	YES NO

OTHER

Allergies (type)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Cancer (type)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Smoke cigarettes (# per day)	Dr. ______________	Date of Diagnosis: _________________	YES NO
Alcoholic beverages (# per week)	Dr. ______________	Date of Diagnosis: _________________	YES NO

Please list all medications below (including vitamins, minerals, aspirin, hormones, water pills, etc…				
Medication	**DOSE**	**Quantity per day**	**Date Started**	**Date Stopped**

Please list any known drug allergies: ____

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