

Patient Health Questionnaire - page 2

American Chiropractic Network

ACN Use Only rev 4/23/99

Patient Name _____ Date _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height

--	--	--

 Weight

--	--	--

 lbs.
Feet Inches

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

- | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <table border="0" style="width: 100%;"> <tr><td style="width: 10%;">Past</td><td style="width: 10%;">Present</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Headaches</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Neck Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Upper Back Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Mid Back Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Low Back Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Shoulder Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Elbow/Upper Arm Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Wrist Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hand Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hip/Upper Leg Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Knee/Lower Leg Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ankle/Foot Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Jaw Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Joint Swelling/Stiffness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Rheumatoid Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>General Fatigue</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Muscular Incoordination</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Visual Disturbances</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dizziness</td></tr> </table> | Past | Present | | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain | <input type="checkbox"/> | <input type="checkbox"/> | Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain | <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> | Hip/Upper Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> | Knee/Lower Leg Pain | <input type="checkbox"/> | <input type="checkbox"/> | Ankle/Foot Pain | <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain | <input type="checkbox"/> | <input type="checkbox"/> | Joint Swelling/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue | <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination | <input type="checkbox"/> | <input type="checkbox"/> | Visual Disturbances | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <table border="0" style="width: 100%;"> <tr><td style="width: 10%;">Past</td><td style="width: 10%;">Present</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>High Blood Pressure</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Heart Attack</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chest Pains</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Stroke</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Angina</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Kidney Stones</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Kidney Disorders</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bladder Infection</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Painful Urination</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Loss of Bladder Control</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Prostate Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abnormal Weight Gain/Loss</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Loss of Appetite</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abdominal Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ulcer</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hepatitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Liver/Gall Bladder Disorder</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cancer</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tumor</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chronic Sinusitis</td></tr> </table> | Past | Present | | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection | <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight Gain/Loss | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gall Bladder Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Tumor | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis | <table border="0" style="width: 100%;"> <tr><td style="width: 10%;">Past</td><td style="width: 10%;">Present</td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Excessive Thirst</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Frequent Urination</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Smoking/Use Tobacco Products</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Drug/Alcohol Dependence</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Depression</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Systemic Lupus</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Epilepsy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dermatitis/Eczema/Rash</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>HIV/AIDS</td></tr> <tr><td colspan="3">Females Only</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Birth Control Pills</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hormonal Replacement</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pregnancy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> 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type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | Females Only | | | <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills | <input type="checkbox"/> | <input type="checkbox"/> | Hormonal Replacement | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy | <input type="checkbox"/> | <input type="checkbox"/> | | Other Health Problems/Issues | | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> | |
| Past | Present | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Elbow/Upper Arm Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hip/Upper Leg Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Knee/Lower Leg Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Ankle/Foot Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Jaw Pain | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint Swelling/Stiffness | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | General Fatigue | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscular Incoordination | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Females Only | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Hormonal Replacement | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Other Health Problems/Issues | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Indicate if an immediate family member has had any of the following:

- Rheumatoid Arthritis Heart Problems Diabetes Cancer Lupus _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and times you have been hospitalized:

Patient Signature _____ Date _____

Doctor's Additional Comments

Doctors Signature _____ Date _____