17. Non Drug Allergies. (Please list allergies and how you react to those substances.) _____

_____

FAMILY HISTORY

18. Please complete the chart below indicating as much information as you know about your family.

General Family	Alive	Deceased	Health Conditions		Alive	Deceased	Health Conditions
Father	☐	☐	_____	Son(s)	☐	☐	_____
Mother	☐	☐	_____	Daughter(s)	☐	☐	_____
Brother(s)	☐	☐	_____	Sister(s)	☐	☐	_____
Paternal Grandfather	☐	☐	_____	Maternal Grandfather	☐	☐	_____
Paternal Grandmother	☐	☐	_____	Maternal Grandmother	☐	☐	_____

SOCIAL HISTORY

19. Do you use any of the following regularly? (circle) Tobacco Alcohol Caffeine White Sugar Illegal Drugs Restricted Diet

20. Please list any medications or nutritional supplements that you are currently taking. _____

_____

21. Please rate the following. 0=Not Affected, 1=Annoying, 2=Painful but Not Limited, 3=Difficult to Perform, 4=Unable to Perform

Household Chores:	0---1---2---3---4	Sexual Activities:	0---1---2---3---4	Shaving:	0---1---2---3---4	Exercise:	0---1---2---3---4
Climbing Stairs:	0---1---2---3---4	Sleeping:	0---1---2---3---4	Dressing:	0---1---2---3---4	Work Tasks:	0---1---2---3---4
Looking Up:	0---1---2---3---4	Sitting:	0---1---2---3---4	Lifting:	0---1---2---3---4	Yard Work:	0---1---2---3---4
Looking Down:	0---1---2---3---4	Standing:	0---1---2---3---4	Driving:	0---1---2---3---4	Recreation:	0---1---2---3---4
Carrying Groceries:	0---1---2---3---4	Daily Pet Care:	0---1---2---3---4	Bending:	0---1---2---3---4	Gripping:	0---1---2---3---4
Change Positions:	0---1---2---3---4	Kneeling:	0---1---2---3---4	Walking:	0---1---2---3---4	Computer Use:	0---1---2---3---4

22. Please describe your type of work and daily work duties. _____

23. Is there anything that you would like to discuss that has not been covered here? _____

REVIEW OF SYSTEMS

24. Please circle any of the conditions below that you have had in the past 1 year or are currently experiencing.

Constitutional	Frequent Colds	Gastrointestinal	Painful Menses	Skin	Appetite Changes
Fever	Nasal Congestion	Apetite Loss	Urine Retention	Rash or Hives	Suicidal Thoughts
Chills	Nose bleeds	Difficulty Swallowing	Vaginal Bleeding	Nail Texture Change	Sleep Disturbance
Drowsiness	Post Nasal Drip	Heartburn	Vaginal Discharge	Skin Color Change	Hematology/Lymph
Fatigue	Sinus Pain/Infections	Nausea	Miscarriage(s)	Hair Growth	Anemia
Night Sweats	Hoarseness	Vomiting Blood	Difficult Pregnancy	Hair Loss	Blood Clotting Problems
Weight Gain	Sore Throats	Rectal Bleeding	Male	Excessive Sweating	Blood Transfusion(s)
Weight Loss	Bleeding Gums	Constipation	Burning Urination	Skin Lesions or Ulcers	Bruises easily
Eyes	Tooth Extraction	Diarrhea	Erectile Dysfunction	Nervous System	Lymph Node Swelling
Blurring	Altered Taste	Abdominal Pain	Frequent Urination	Seizures or Tremors	Lymph Node Tenderness
Double Vision	Abcess	Belching	Hesitancy or Dribbling	Dizziness	GU
Light Sensitivity	Respiratory	Black, Tarry Stools	Prostate Problems	Facial Weakness	Pain in the Side
Eye Pain	Shortness of Breath	Thin Stools	Urine Retention	Headaches	Pain in the Groin
Change in Vision	Wheezing	Hemorrhoids	Endocrine	Limb Weakness	Urinary Urgency
Eye Trauma	Cough	Indigestion	Goiter	Loss of Consciousness	Urinating at Night
Itching	Coughing up blood	Yellow Skin	Cold Intolerance	Loss of Memory	Blood in Urine
Tearing	Sputum Production	Excessive Gas	Heat Intolerance	Numbness	Urinary Hesitancy
Wears Glasses	Cardiovacular	Female	Diabetes	Slurred Speech	STD
Ears, Nose & Throat	Chest Pain	Birth Control Therapy	Excessive Appetite	Unsteadiness of Gait	Urinary Itching
Hearing Loss	Leg Swelling	Breast Lumps/Pain	Excessive Thirst	Psychological	Prior Kidney Stones
Ear Pain	Leg Pain/Aching	Burning Urination	Frequent Urination	Depression	
Ear Discharge	Heart Murmur	Cramps	Hair Loss	Mood Changes	
Ear Ringing	Heart Palpitations	Frequent Urination	Unusual Hair Growth	Confusion	
Dizziness	Ulcers	Hormone Therapy	Voice Changes	Anxiety/Nervousness	
Loss of Smell	Varicose Veins	Irregular Menstruation		Irritability	

Reviewed by: _____ D.C.