Past medical history (circle):
Illnesses: Cancer Diabetes Hepatitis Hypertension Seizures
Heart Disease Thyroid Disease Asthma
Surgeries :

Significant trauma (auto acc., falls, etc.):

Allergies (drugs, chemicals, food):

Family Medical History (Indicate Mom or Dad): Diabetes Cancer

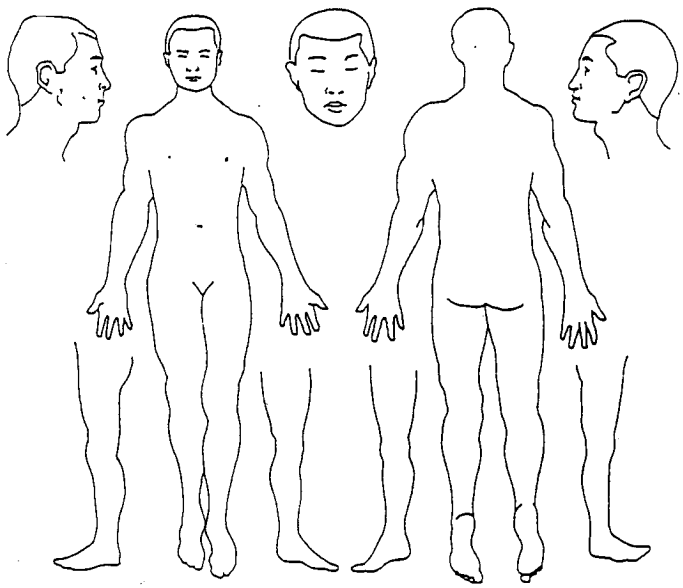
Hypertension Seizures Asthma Allergies Heart Disease Stroke

Occupation :
Job stress (chemical, physical, psychological)

Exercise : What kind of exercise and how often?

Medicines taken within the last 2 months (inc. vitamins, prescriptions, herbs)

Describe your daily diet:
Morning: Noon: Evening:

Habits (circle): cigarettes coffee tea cola alcohol drugs
sugar salt other_____

Indicate painful or distressed areas: