

Rising Tide



Natural Medicine

50 Forest Falls Dr., Ste 5
Phone (207) 865-1222

Yarmouth, ME 04096
risingtide@suscom-maine.net

Registration Form

Full Name _____ Date of Initial Visit _____

Social Security Number(SSN) _____ Birth Date _____ Age _____

Home Mailing Address _____ Home Phone _____

City,State,Zip _____ E-mail _____

Occupation _____ Cell/Pager Phone _____

Employer _____ Business Phone _____

Business Address _____ Fax _____

Emergency Contact _____ Relation _____

Contact Address _____ Contact Phone _____

Contact Business Address _____ Contact Cell/Bus. Phone _____

Sex: Male Female Sexual Orientation: Celibate Heterosexual Homosexual Bisexual

Marital Status: Never married Currently married Separated Divorced Widowed

Living Situation: Alone Parents Spouse Significant Other Friend Boarding

Number Siblings _____ Number Children _____ Number Marriages _____ Number Cohabitants(Live with) _____

Referred by _____ Relation _____

Primary Care Provider (PCP) _____ May we correspond with the referrer? Yes No

PCP Address _____ PCP Phone Number _____

Do you have an Advance Directive for Health Care (Living Will)? Yes No

If you have any other medical records or test results, please bring them so we can review them or make copies.

Please List Your Primary Health Concerns in Order of Importance or Severity:

1) _____

2) _____

3) _____

4) _____

Please List Your Primary Stresses in Order of Importance or Severity:

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

I understand that I am required to make payment in full at the time of service and insurance reimbursement is my own responsibility.
I authorize the release of medical information relative to treatment received to insurance companies responsible for reimbursement.

General Health Questionnaire

Please check if you have experienced the problem currently or recurrently (Yes), severely or frequently in the past (Past), or never (No).

- | | | |
|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Severe/frequent headache | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent crying |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blackouts/fainting spells | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloating/flatulence | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lonely/depressed |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizzy spells/balance loss | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain in abdomen | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hopeless outlook |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Double vision | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea/loose stools | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Considered suicide |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> See halos/ lights/colors | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Considered homicide |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blurry vision | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Black stools | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Reduced visual field | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gray/white stools | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Persistent thoughts |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pain/dryness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in stools | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frightening thoughts |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching/watery eyes | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain in rectum | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vision worsening | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching rectum | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> See things not there |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wear glasses/contacts | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hear voices |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sensitivity to light/color | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Involuntary loss of urine | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dislike criticism |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earaches | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Burning on urination | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Annoyed at small events |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hearing problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Brown/black/blood urine | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Easily angered |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fluid from ears | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Weak urine stream | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Noises in ears | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty starting urine | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Change in sexual desire |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sensitivity to noises | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dribbling after urination | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Family problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constant urge to urinate | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Relationship problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore/bleeding gums | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Aching muscles/joints | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Problems with work |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore tongue | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen joints | MEN |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Facial pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Burning/discharge |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen neck/glands | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Scalp/neck pain | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps/swelling testicles |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulder/arm pain/weak | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful testicles |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarse voice | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hand/finger pain/weak | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Erection problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested nose | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Back pain/weakness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Running nose | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rib pain | WOMEN (or mother if patient is a child) |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sneezing spells | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hip/leg pain/weakness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling/lumps in breasts |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent head colds | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot/toe pain/weakness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful breasts |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Paralysis | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Genital irritation |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sensitive to smells | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin growths/Warts | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor sense of smell | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin rashes/Acne | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bearing down feeling |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing or gasping | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching/burning skin | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Problems before periods |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent chest colds | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hair/nail problems | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful periods |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent coughing | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Perspiration/night sweats | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bleeding between period |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cough up phlegm | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever/chills | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Miss period(not pregnant) |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cough up blood | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Light periods |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid/skipped heartbeats | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue/weariness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Heavy periods |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pains | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervous/anxious | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervous with strangers | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain on intercourse |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen feet or ankles | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nail biting | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Infertility problems |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficulty relaxing | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pregnancy complications |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Easy bruising/bleeding | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Worry a lot | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Birth complications |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Recurring indigestion | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Overwhelmed | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Postpartum complications |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent belching | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sensitive or shy | _____ Number of pregnancies |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Trouble making decisions | _____ Number of births/ cesareans |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Motion sickness | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lack of concentration | _____ Number of premature births |
| | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor memory/forgetful | _____ Number of miscarriages |
| | | _____ Number of abortions |
| | | _____ Number of abnormal paps |

Medical History

Please include even if the person is now deceased. Change column headings to adjust for your family's composition. **Grand- Grand-**

	You	Father	Mother	Sibling	Sibling	Sibling	Child	Child	Child	Parent	Parent
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/Bruising	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drinking/Drug problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV Positive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infections frequently	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney/Bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Periods abnormal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/Intestinal problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis/PPD+	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain/loss problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Familial Conditions: _____

Allergies (including medications): _____

Hospitalizations/Surgeries:

Month/Year _____ Type of Illness/Operation _____

Month/Year _____ Type of Illness/Operation _____

Month/Year _____ Type of Illness/Operation _____

Month/Year _____ Type of Illness/Operation _____

Month/Year _____ Type of Illness/Operation _____

Immunizations (note any adverse reactions):

MMR

DPT

Hepatitis

Polio

Typhoid

Other _____

Please estimate the type and amount you currently or regularly consume (may use other side):

Blood Pressure/Heart Meds: _____

Alcohol: _____

Birth Control/Hormone Replacement: _____

Beer: _____

Cortisone/Prednisone: _____

Coffee: _____

Laxatives: _____

Cigarettes: _____

Pain Meds/Analgesics: _____

Cigars/Chew: _____

Sedatives/Tranquilizers: _____

Vitamins: _____

Stimulants: _____