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**Patient Name:**

**Date:**

**PAST HEALTH HISTORY:** Have you been diagnosed with any of the following?

Brief Description

approximate date

1. Dizziness
2. Backaches
3. Diabetes
4. Heart conditions, includes high blood pressure, high cholesterol
5. Arthritis
6. Headaches
7. Extremity numbness, tingling, weakness
8. Asthma
9. Nerve condition
10. Digestive Disorders
11. Cancer
12. Seizures, concussion or loss of consciousness
13. Bleeding disorders

**FAMILY HISTORY:**

1. Heart disease:
2. Diabetes/sugar disorders:
3. Hypertension:
4. Arthritis:
5. Cancer:

Do you suffer from? Chest pain \_\_\_\_ ; nausea \_\_\_\_ : palpitations \_\_\_\_ ; shortness of breath \_\_\_\_ ;

Anxiety \_\_\_\_ ; Vomiting \_\_\_\_ ; Night sweats \_\_\_\_ ; Tremors \_\_\_\_ ; Fatigue \_\_\_\_ ; Chills

Tobacco use \_\_\_\_ ; High fat diet \_\_\_\_ ; Use artificial sweeteners \_\_\_\_ ; Drink diet pop \_\_\_\_

