

MEDICAL AND SURGICAL HISTORY

<p>GENERAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Headaches/migraines <input type="checkbox"/> Blackout <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Sinus problems <input type="checkbox"/> History of falls <input type="checkbox"/> Balance disturbance <input type="checkbox"/> Vision loss <input type="checkbox"/> Hearing loss <input type="checkbox"/> Memory loss <input type="checkbox"/> Insomnia 	<p>CARDIOVASCULAR/BLOOD</p> <ul style="list-style-type: none"> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart attack/MI <input type="checkbox"/> Heart disease <input type="checkbox"/> CHF <input type="checkbox"/> Aneurysm <input type="checkbox"/> Bleeding disorder <input type="checkbox"/> Blood clots/DVT <input type="checkbox"/> Anemia <input type="checkbox"/> Chest pain/angina <input type="checkbox"/> Arrythmia <input type="checkbox"/> High cholesterol 	<p>DIGESTIVE</p> <ul style="list-style-type: none"> <input type="checkbox"/> IBS <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Celiac Disease <input type="checkbox"/> GERD/Gastritis <input type="checkbox"/> Ulcer _____ <input type="checkbox"/> Frequent loose stools <input type="checkbox"/> Frequent constipation <input type="checkbox"/> Discomfort after meals <input type="checkbox"/> Hernia <input type="checkbox"/> Swallowing dysfunction <input type="checkbox"/> Liver disorder
<p>MUSCULOSKELETAL/ORTHOPEDIC</p> <ul style="list-style-type: none"> <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fractures _____ <input type="checkbox"/> Compression fracture <input type="checkbox"/> Stress fracture <input type="checkbox"/> Dislocation <input type="checkbox"/> Inguinal hernia <input type="checkbox"/> Hernia (other) _____ <input type="checkbox"/> Diastasis recti <input type="checkbox"/> Carpal tunnel <input type="checkbox"/> Thoracic Outlet Syndrome <input type="checkbox"/> Spinal stenosis <input type="checkbox"/> Sciatica <input type="checkbox"/> Spondylolisthesis <input type="checkbox"/> Herniated disc <input type="checkbox"/> TMD <input type="checkbox"/> Other ortho injuries _____ 	<p>IMMUNE/ENDOCRINE/METABOLIC</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes Type 1 or 2 (circle) <input type="checkbox"/> Low blood sugar <input type="checkbox"/> Hepatitis A B C <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> TB <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Thyroid dysfunction <input type="checkbox"/> Autoimmune disease _____ <input type="checkbox"/> Osteoporosis/Osteopenia <input type="checkbox"/> Gout <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Inflammatory condition _____ 	<p>SURGICAL HISTORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> CABG/Bypass surgery <input type="checkbox"/> Pacemaker/defibrillator <input type="checkbox"/> Vascular surgery/stents <input type="checkbox"/> Abdominal surgery <input type="checkbox"/> Gastric bypass surgery <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Laparoscopy <input type="checkbox"/> Bladder surgery <input type="checkbox"/> C-section <input type="checkbox"/> Hernia surgery <input type="checkbox"/> Gallbladder surgery <input type="checkbox"/> Orthopedic surgery <input type="checkbox"/> Back/neck surgery <input type="checkbox"/> Plastic surgery <input type="checkbox"/> Other surgeries _____ _____
<p>UROGENITAL/GYNECOLOGICAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Urological disorder <input type="checkbox"/> Kidney disease _____ <input type="checkbox"/> Incontinence <input type="checkbox"/> Endometriosis <input type="checkbox"/> Dysmenorrhea <input type="checkbox"/> Gynecological disorder <input type="checkbox"/> Fibroids/cysts <input type="checkbox"/> # of childbirths _____ 	<p>RESPIRATORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Pneumonia <input type="checkbox"/> Allergies <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Deviated septum <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other lung disorders 	<p>NERVOUS SYSTEM</p> <ul style="list-style-type: none"> <input type="checkbox"/> Head/brain injury <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> MS <input type="checkbox"/> Peripheral neuropathy <input type="checkbox"/> Epilepsy/seizure disorder <input type="checkbox"/> Parkinson's <input type="checkbox"/> Neuromuscular disorder <input type="checkbox"/> Other neuro disorder
<p>TRAUMA</p> <ul style="list-style-type: none"> <input type="checkbox"/> Whiplash <input type="checkbox"/> Motor vehicle accident <input type="checkbox"/> Concussion <input type="checkbox"/> Other trauma 	<p>NUTRITIONAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nutritional deficiency <input type="checkbox"/> Food allergies <input type="checkbox"/> Eating disorder 	<p>FAMILY HISTORY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer