

Blood/Lymph Systems

	You	Family
Bleeding, nose, skin, internal	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Slow clotting time	<input type="checkbox"/>	<input type="checkbox"/>
Swollen lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>

Stomach/Intestines

Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Gallstones	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>

Urinary

Kidney disorder	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Herpes simplex	<input type="checkbox"/>	<input type="checkbox"/>
Change in urination	<input type="checkbox"/>	<input type="checkbox"/>

Pregnancy

Are you currently pregnant?

Endocrine

	You	Family
High or low glucose	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>
Non-insulin dependent	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>
Thirst/hunger change	<input type="checkbox"/>	<input type="checkbox"/>

Skin

Eczema/psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric

Depression/mood swings

Allergic

Seasonal allergies

Anaphylactic reactions

Are you presently nursing?

Drug Allergies: _____

Name of Current Medications: _____

List of Surgery and Dates(Women, please include C-Sections): _____

Date of Last Physical Exam: _____

Name of Medical Doctor: _____

Please Stop Here

Physician's Signature: _____

Date: _____