Is there any family history (in parents, siblings or children) of any of the following:

Arthritis	❑ No	❑ Yes	Who: _____
Lupus	❑ No	❑ Yes	Who: _____
Scleroderma	❑ No	❑ Yes	Who: _____
Muscle Disease	❑ No	❑ Yes	Who: _____
Psoriasis	❑ No	❑ Yes	Who: _____
Crohn's Disease or Ulcerative Colitis	❑ No	❑ Yes	Who: _____
Multiple Sclerosis	❑ No	❑ Yes	Who: _____
Cancer	❑ No	❑ Yes	Who: _____
Blood Disorders	❑ No	❑ Yes	Who: _____

Review of Systems

Do you have, or have you had in the past three months, any of the following (please check those you have experienced):

General
- ❑ Fever (over 100 degrees)
- ❑ Weight loss
- ❑ Night sweats
- ❑ Loss of energy
- ❑ Change in lymph nodes
- ❑ Snoring
- ❑ Trouble sleeping

Ears
- ❑ Ringing
- ❑ Loss of hearing

Eyes
- ❑ Trouble seeing
- ❑ Red or inflamed eyes
- ❑ Eye pain

Nose and Mouth
- ❑ Nose bleeds
- ❑ Mouth sores (ulcers, canker sores)
- ❑ Sinus pain
- ❑ Nasal congestion
- ❑ Nose bleeds

Neck
- ❑ Goiter
- ❑ Difficulty swallowing

Breasts
- ❑ Discharge from nipples
- ❑ Lumps

Cardiovascular
- ❑ Chest pain
- ❑ Difficulty breathing
- ❑ Leg swelling
- ❑ Palpitations

Pulmonary
- ❑ Wheezing
- ❑ Cough
- ❑ Pain with breathing
- ❑ Cough up blood

Digestive
- ❑ Loss of appetite
- ❑ Heartburn
- ❑ Nausea or vomiting
- ❑ Abdominal pain
- ❑ Constipation

Genitourinary
- ❑ Burning on urination
- ❑ Bloody urine or discharge
- ❑ Difficulty urinating
- ❑ Urination at night, # of times_____
- ❑ Sexually transmitted diseases

Brain and Nerves and Muscles
- ❑ Seizures or epilepsy
- ❑ Dizziness
- ❑ Blackouts
- ❑ Weakness
- ❑ Stroke
- ❑ Headaches
- ❑ Depression
- ❑ Numbness
- ❑ Muscle pain

Blood
- ❑ Easy bruising
- ❑ Excessive bleeding

Skin
- ❑ Rashes
- ❑ Fingers changing color

Your Past Medical History

Please check those you have had:

- ❑ Polio
- ❑ Valley Fever
- ❑ Exposure to TB
- ❑ Tuberculosis
- ❑ Pneumonia
- ❑ Pleurisy
- ❑ Hepatitis / Liver Disease
- ❑ Bladder Infections
- ❑ Kidney Disease
- ❑ Hay Fever
- ❑ Asthma
- ❑ Emphysema
- ❑ Back Trouble
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Stroke
- ❑ Anemia
- ❑ Bleeding Tendency
- ❑ Ulcer (stomach or intestine)
- ❑ Cancer
- ❑ Blood Transfusion
- ❑ Thyroid Disease
- ❑ Diabetes
- ❑ Mental Health Problem
- ❑ Epilepsy / Seizures
- ❑ Osteoporosis

Operations (Check if Yes)

- ❑ Tonsils ..... Year: _____
- ❑ Appendix ..... Year: _____
- ❑ Gallbladder ..... Year: _____
- ❑ Stomach ..... Year: _____
- ❑ Breast ..... Year: _____
- ❑ Uterus and/or Ovary ..... Year: _____
- ❑ Prostate ..... Year: _____
- ❑ Hernia ..... Year: _____
- ❑ Thyroid ..... Year: _____
- ❑ Varicose Veins ..... Year: _____
- ❑ Hemorrhoid ..... Year: _____
- ❑ Heart ..... Year: _____
- ❑ Spine (back or neck) ..... Year: _____
- ❑ Joint Replacement ..... Year: _____
- ❑ Other (please list): _____

Injuries or Accidents

- ❑ Head ..... Year: _____
- ❑ Broken Bones ..... Year: _____
- ❑ Other (please list): _____

Any work-related injuries (please list): _____