

PERSONAL AND FAMILY MEDICAL HISTORY



CANCER/ONCOLOGY	GYNECOLOGY	MUSCULOSKELETAL/RHEUMATOLOGIC
<input type="checkbox"/> Cancer – Type _____ <input type="checkbox"/> Cancer – Type _____ <input type="checkbox"/> Cancer – Type _____ <input type="checkbox"/> Skin Cancer - Basal Cell <input type="checkbox"/> Skin Cancer - Squamous Cell <input type="checkbox"/> Skin Cancer - Melanoma	<input type="checkbox"/> Chlamydia <input type="checkbox"/> Endometriosis <input type="checkbox"/> Fibroids <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Osteopenia <input type="checkbox"/> Polycystic ovary syndrome (PCOS)	<input type="checkbox"/> Bursitis <input type="checkbox"/> Carpal Tunnel Syndrome <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Chronic Joint Pains
CARDIOLOGY/HEMATOLOGIC	OTHER	PSYCHOLOGICAL
<input type="checkbox"/> Anemia <input type="checkbox"/> Aortic Value Disorder <input type="checkbox"/> Bleeding / Clotting Disorder <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Disease - Arrhythmia/A-Fib <input type="checkbox"/> Heart Disease - Pacemaker <input type="checkbox"/> Heart Disease - Stent <input type="checkbox"/> Heart Disease - implanted cardio defibrillator <input type="checkbox"/> Heart Murmur /Mitral Valve Prolapse <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Peripheral Vascular Disease <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Heart Value Disorders <input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Leukemia <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug User <input type="checkbox"/> Smoker VIRUSES <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Shingles <input type="checkbox"/> Epstein Barr <input type="checkbox"/> Mononucleosis GASTROINTESTINAL <input type="checkbox"/> Appendicitis <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Gall Stones <input type="checkbox"/> Gastrointestinal Bleeding <input type="checkbox"/> GERD (Acid Reflux) <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis A, B, or C <input type="checkbox"/> Irritable Bowel Syndrome/Chrohn's Disease <input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> PTSD <input type="checkbox"/> OCD
		RESPIRATORY
		<input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis/Pneumonia <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Other Lung Disease
		UROLOGICAL
		<input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Dialysis (Hemo/Peritoneal) <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Urinary Tract/Kidney infection
ENDOCRINOLOGY	NEUROLOGICAL	<input type="checkbox"/> ANESTHESIA COMPLICATIONS
<input type="checkbox"/> Diabetes – Type _____ <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Alzheimer's <input type="checkbox"/> Balance Disorders <input type="checkbox"/> Dementia <input type="checkbox"/> Epilepsy <input type="checkbox"/> Head Injury <input type="checkbox"/> Headaches <input type="checkbox"/> Lupus <input type="checkbox"/> Lyme Disease <input type="checkbox"/> Meningitis <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Neuropathy <input type="checkbox"/> Parkinson's <input type="checkbox"/> Seizures <input type="checkbox"/> Traumatic Brain Injury (TBI)	<input type="checkbox"/> ALLERGIES
ENT		
<input type="checkbox"/> Glaucoma <input type="checkbox"/> Vertigo <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Nosebleeds		