Medical History Checklist

Patient Name: _____ Date: _____

Medical History		
Alcoholism	☐ Yes	☐ No
Alzheimer's	☐ Yes	☐ No
Amblyopia	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Aneurysm	☐ Yes	☐ No
Arrhythmia	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Biliary Tract Disease	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No
Blindness	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Cataplexy	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Chronic Pain	☐ Yes	☐ No
Cirrhosis	☐ Yes	☐ No
Collapsed Lung	☐ Yes	☐ No
Colorblindness	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Coronary Artery Disease	☐ Yes	☐ No
Crohn's Disease	☐ Yes	☐ No
Cryptococcus	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No
Cytomegalovirus	☐ Yes	☐ No
Degenerative Arthritis	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Dermatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Ectopic Pregnancy	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Erectile Dysfunction	☐ Yes	☐ No
Gallstones	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Glomerulonepritis	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Hearing Impairment	☐ Yes	☐ No
Hepatitis A	☐ Yes	☐ No
Hepatitis B	☐ Yes	☐ No
Hepatitis C	☐ Yes	☐ No
HIV	☐ Yes	☐ No

Medical History (Cont.)		
Hypertension	☐ Yes	☐ No
Hyperthyroidism	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No
Immune Deficiency	☐ Yes	☐ No
Infections (chronic)	☐ Yes	☐ No
Infertility	☐ Yes	☐ No
Insomnia	☐ Yes	☐ No
Ischemic Bowel Disease	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Lyme Disease	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No
MAI	☐ Yes	☐ No
Menopause	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Narcolepsy	☐ Yes	☐ No
Nephrotic Syndrome	☐ Yes	☐ No
Ocular Misalignment	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Ovarian Cysts	☐ Yes	☐ No
Pancreatitis	☐ Yes	☐ No
Parkinson's Disease	☐ Yes	☐ No
Peripheral Neuropathy	☐ Yes	☐ No
Pleural Effusion	☐ Yes	☐ No
Prostate Enlarged	☐ Yes	☐ No
Prostatitis (chronic)	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No
Pulmonary Embolism	☐ Yes	☐ No
Pulmonary Fibrosis	☐ Yes	☐ No
Reflux Esophagitis	☐ Yes	☐ No
Renal Failure	☐ Yes	☐ No
Retinal Detachment	☐ Yes	☐ No
Rheumatoid Arthritis	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No
Sinusitis (chronic)	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
Somnambulism	☐ Yes	☐ No
Spina Bifida	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Thalassemia	☐ Yes	☐ No
Tinnitus	☐ Yes	☐ No
Toxoplasmosis	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Ulcers	☐ Yes	☐ No