

Health History

Have you ever had any of the following:

If yes, when was the Condition first apparent?

YES	NO	Head Injury with loss of consciousness	_____
YES	NO	Seizures	_____
YES	NO	Stroke	_____
YES	NO	Heart Attack	_____
YES	NO	Rheumatic Fever	_____
YES	NO	Rheumatic Heart Disease	_____
YES	NO	Heart Murmur	_____
YES	NO	Congestive Heart Failure	_____
YES	NO	Angina	_____
YES	NO	Cardiovascular Disease	_____
YES	NO	High Blood Pressure	_____
YES	NO	Tumor or Cancer	_____
YES	NO	High Cholesterol	_____
YES	NO	Diabetes	_____
YES	NO	Thyroid Condition	_____
YES	NO	Incontinence	_____
YES	NO	Asthma	_____
YES	NO	Emphysema	_____
YES	NO	COPD	_____
YES	NO	Liver Disease	_____
YES	NO	Kidney Disease	_____
YES	NO	Sleep Apnea	_____
YES	NO	Alcohol Abuse	_____
YES	NO	Drug Abuse	_____
YES	NO	Osteoarthritis	_____
YES	NO	Rheumatoid Arthritis	_____
YES	NO	Psoriasis	_____
YES	NO	Stomach Ulcers	_____
YES	NO	Tuberculosis	_____
YES	NO	Depression	_____
YES	NO	Anxiety	_____
YES	NO	Anemia	_____
YES	NO	Venereal Disease	_____

YES	NO	Do you see your physician on a regular basis? When was your last physical?	_____
YES	NO	Are you currently being treated for any chronic illness? If so, please list	_____

The doctor will *free* you now.

