Patient's Name: _____

Past Medical History

Yes	No	Nature of Problem	Comments/Approximate Date of Diagnosis
		AIDS/HIV	
		Alzheimers/Dementia	
		Anemia	
		Anxiety/Depression	
		Arthritis (Osteo/Rheumatoid/Unsure)	
		Asthma/Shortness of Breath	
		Back Problems	
		Cancer (Type)	
		Chest Pain	
		Circulation Problems/PVD	
		Clotting Disorder/DVT	
		Congestive Heart Failure	
		COPD	
		Diabetes Insulin Dependent	
		Diabetes Non Insulin Dependent	
		Dizziness/Fainting	
		Fibromyalgia	
		Gall Bladder Disease	
		GERD/Reflux	
		Gout	
		Headaches	
		Hearing Impairment	
		Heart Disease	
		Heart Murmur	
		Hepatitis	
		High Cholesterol	
		High Blood Pressure	
		Kidney Disease/Stones	
		Leg/Foot Cramps	
		Liver Disease	
		Mitral Valve Prolapse	
		Numbness in Feet	
		Osteoporosis/Osteopenia	
		Restless Leg Syndrome	
		Seizures	
		Skin Condition (Type)	
		Stroke	
		Swelling Feet/Legs	
		Thyroid Disorder	
		Tuberculosis	
		Varicose Veins	
		Vision Impairment	
		Weight Changes	
		*Any Other Problems or Illness	