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**Section II - Required**

**Personal History**

Have you had or are you now experiencing any of the following? If yes, not date of occurrence if known:

**Head/neurological**

	Yes	No	Date
Frequent headaches/migraines	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dizziness or fainting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Eyes**

Vision or eye problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glasses or contact lenses	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Ear/nose/throat**

Allergies or hay fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear of hearing problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dental problems or TMJ	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Skin**

Severe acne or skin disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
New or changing moles	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Blood disorder**

Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Enlargement of glands or lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Heart/circulation/chest**

Severe chest pain or pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart disease or murmur	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rapid or irregular pulse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood clots or vein problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Respiratory**

Chronic cough (over 1month)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis or positive PPD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Yes	No	Date
<b>Gastrointestinal</b>			
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel movement problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Musculoskeletal**

Swollen or painful joints or extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic or severe back problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Chronic diseases**

Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Elevated cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Genitourinary**

Urinary or kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
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**Additional medical history**

Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unusual fatigue (over 1 month)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recent gain or loss of Weight (over 10 pounds)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other: \_\_\_\_\_

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**Section III – Optional (Recommended)**

**\*\*ALL OF THE FOLLOWING INFORMATION\*\*  
IS TO BE COMPLETED BY A PHYSICIAN**

**Measurements**

Height \_\_\_\_\_ Weight \_\_\_\_\_

**Vital Signs**

Pulse \_\_\_\_\_ Blood pressure \_\_\_\_\_ / \_\_\_\_\_

**Vision**

Right 20/\_\_\_\_\_ Corrected to 20/\_\_\_\_\_ Left 20/\_\_\_\_\_ Corrected to 20/\_\_\_\_\_

**Laboratory (if indicated)**

Results	Results	Results
CBC _____	Urinalysis _____	Other _____
Serology _____	Sickle Cell _____	Other _____

**PHYSICAL EXAMINATION**

<b>SYSTEMS</b>	<b>FINDINGS</b>
General appearance	
HEENT	
Cardiovascular	
Lungs	
Breast	
Abdomen	
Genitalia	
Musculoskeletal	
Spine	
Skin and lymphatic	
Neurological	

**SUMMARY OR ASSESSMENT AND DIAGNOSIS:** \_\_\_\_\_

**RECOMMENDATIONS:** \_\_\_\_\_

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Typed/printed name of physician

Signature

Date

