



**Current and Past Medical Conditions**  
(Please Check Only the Ones That Apply To You)

<u>Y</u> <u>N</u> <u>Date of Diagnosis</u>	<u>Y</u> <u>N</u> <u>Date of Diagnosis</u>
<u>Heart Disease</u>	<u>High Blood Pressure</u>
<u>Stroke</u>	<u>Varicose Veins</u>
<u>Clotting Defects</u>	<u>Diabetes</u>
<u>Kidney Trouble</u>	<u>Epilepsy</u>
<u>Recent Fractures</u>	<u>Arthritis</u>
<u>Colitis</u>	<u>Gallbladder Trouble</u>
<u>Irritable Bowel</u>	<u>Asthma</u>
<u>Ulcers</u>	<u>Autoimmune Disorder</u>
<u>Fibromyalgia</u>	<u>Osteoporosis</u>
<u>Chronic Fatigue</u>	<u>Cancer</u>
<u>Eating Disorder</u>	<u>Liver Disease</u>

**Habits:**

<u>Do You Get Routine Exercise</u>	<u>Y</u> <u>N</u>	<u>What Type</u>	<u>How Often</u>
<u>Do You Use Tobacco Products</u>	<u>Y</u> <u>N</u>	<u>How Much</u>	<u>How Long</u>
<u>Do You Use Alcohol Products</u>	<u>Y</u> <u>N</u>	<u>How Much</u>	<u>How Long</u>
<u>Do You Use Caffeine Products</u>	<u>Y</u> <u>N</u>	<u>How Much</u>	<u>How Long</u>

**Family History:**

<b>Relative</b>	<b>Breast Cancer</b>	<b>Heart Disease</b>	<b>Diabetes</b>
<u>Mother</u>			
<u>Father</u>			
<u>Brother</u>			
<u>Sister</u>			
<u>Aunts</u>			
<u>Uncles</u>			
<u>Paternal Grandmother</u>			
<u>Paternal Grandfather</u>			
<u>Maternal Grandmother</u>			
<u>Paternal Grandfather</u>			

**Please Fax Results to 505-864-6535**