

IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS, CHECK THE APPROPRIATE BOX OR BOXES.

Past	Present	Past	Present	Past	Present
	General		Gastro-Intestinal		Eyes, Ears, Nose & Throat
<input type="checkbox"/>	<input type="checkbox"/> Allergy	<input type="checkbox"/>	<input type="checkbox"/> Constipation	<input type="checkbox"/>	<input type="checkbox"/> Eye Pain
<input type="checkbox"/>	<input type="checkbox"/> Convulsion	<input type="checkbox"/>	<input type="checkbox"/> Diarrhea	<input type="checkbox"/>	<input type="checkbox"/> Near or Farsighted
<input type="checkbox"/>	<input type="checkbox"/> Dizziness	<input type="checkbox"/>	<input type="checkbox"/> Difficult/Painful Digestion	<input type="checkbox"/>	<input type="checkbox"/> Light Bothers Eyes
<input type="checkbox"/>	<input type="checkbox"/> Fainting	<input type="checkbox"/>	<input type="checkbox"/> Shortness of Breath After Eating	<input type="checkbox"/>	<input type="checkbox"/> Deafness
<input type="checkbox"/>	<input type="checkbox"/> Fatigue	<input type="checkbox"/>	<input type="checkbox"/> Ulcers	<input type="checkbox"/>	<input type="checkbox"/> Earaches
<input type="checkbox"/>	<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/> Intestinal Gas	<input type="checkbox"/>	<input type="checkbox"/> Ear Noises
<input type="checkbox"/>	<input type="checkbox"/> Headache	<input type="checkbox"/>	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/> Sinus
		<input type="checkbox"/>	<input type="checkbox"/> Heartburn		
		<input type="checkbox"/>	<input type="checkbox"/> Hiatal Hernia		
	Muscle & Joints		Genito-Urinary		Cardiovascular
<input type="checkbox"/>	<input type="checkbox"/> Jaw Problems	<input type="checkbox"/>	<input type="checkbox"/> Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/> Grinding or Clenching Teeth	<input type="checkbox"/>	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/> Poor Circulation
<input type="checkbox"/>	<input type="checkbox"/> Pain between Shoulders	<input type="checkbox"/>	<input type="checkbox"/> Inability to Control Kidneys	<input type="checkbox"/>	<input type="checkbox"/> Rapid Heartbeat
		<input type="checkbox"/>	<input type="checkbox"/> Kidney Infection or Stones	<input type="checkbox"/>	<input type="checkbox"/> Slow Heartbeat
		<input type="checkbox"/>	<input type="checkbox"/> Painful Urination		
		<input type="checkbox"/>	<input type="checkbox"/> Prostate Trouble		
		<input type="checkbox"/>	<input type="checkbox"/> Pus in Urine		
		<input type="checkbox"/>	<input type="checkbox"/> Bladder Infection		
	Pain or Numbness In:		Respiratory		Women Only
<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/> Congested Breasts
<input type="checkbox"/>	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/> Chest Pain	<input type="checkbox"/>	<input type="checkbox"/> Cramps or Backache
<input type="checkbox"/>	<input type="checkbox"/> Arm	<input type="checkbox"/>	<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/> Excessive Menstruation
<input type="checkbox"/>	<input type="checkbox"/> Elbow	<input type="checkbox"/>	<input type="checkbox"/> Spitting up Blood	<input type="checkbox"/>	<input type="checkbox"/> Menopausal Symptoms
<input type="checkbox"/>	<input type="checkbox"/> Hands	<input type="checkbox"/>	<input type="checkbox"/> Wheezing	<input type="checkbox"/>	<input type="checkbox"/> Irregular Cycle
<input type="checkbox"/>	<input type="checkbox"/> Hip	<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> Lumps in Breasts
<input type="checkbox"/>	<input type="checkbox"/> Legs			<input type="checkbox"/>	<input type="checkbox"/> Painful Menstruation
<input type="checkbox"/>	<input type="checkbox"/> Knees			<input type="checkbox"/>	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/>	<input type="checkbox"/> Feet			<input type="checkbox"/>	<input type="checkbox"/> Endometriosis
				<input type="checkbox"/>	<input type="checkbox"/> Premenstrual Syndrome

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gout	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eczema	<input type="checkbox"/> Heart Disease/Attack	<input type="checkbox"/> Atherosclerosis	<input type="checkbox"/> Measles
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps
<input type="checkbox"/> Cancer	<input type="checkbox"/> Goiter	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Stroke	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Herpes	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Polio	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Hypoglycemia				

Please Indicate If You Have/Have Had Trouble With Any Glands/Organ:

<input type="checkbox"/> Pituitary	<input type="checkbox"/> Stomach
<input type="checkbox"/> Thyroid	<input type="checkbox"/> Small Intestine
<input type="checkbox"/> Pancreas	<input type="checkbox"/> Large Intestine
<input type="checkbox"/> Adrenal	<input type="checkbox"/> Bladder
<input type="checkbox"/> Ovary/Teste	<input type="checkbox"/> Lungs
<input type="checkbox"/> Liver	<input type="checkbox"/> Prostate/Uterus
<input type="checkbox"/> Gall Bladder	

Family History: Have your Mother or Father had any of these disorders?:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Stroke
<input type="checkbox"/> Atherosclerosis	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart Trouble
<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney Disorders
<input type="checkbox"/> Obesity	<input type="checkbox"/> Other Nervous Symptoms
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Spinal Problems

Check Which Meals That You Eat Regularly: Breakfast Lunch Dinner Between Meals Before Bed