

HAVE YOU HAD ANY OF THE FOLLOWING DISEASES?

- Alcoholism Epilepsy Mumps Anemia Goiter Pleurisy Appendicitis Heart Disease Pneumonia
 Arthritis HIV Positive Polio Cancer Influenza Rheumatic Fever Chicken Pox Low Back Pain
 Scoliosis Diabetes Measles Sprain/Strain Sacroiliac Eczema Mental Disorder Whiplash

FAMILY HISTORY

	Diabetes	Heart	Kidney	Cancer	Back
Mother – Living Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father _ Living Y <input type="checkbox"/> N <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s), # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s), # of _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adoption History	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please enter "2" (Previously), "3" (Presently), in front of all the following signs and symptoms. Leave blank if not applicable.

- | | | | |
|--|---|---|------------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> HEADACHES |
| <input type="checkbox"/> ALLERGY | <input type="checkbox"/> ECZEMA | <input type="checkbox"/> MEASLES | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> GALL BLADDER | <input type="checkbox"/> MISCARRIAGE | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> NECK PAIN |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> VENEREAL DISEASE | <input type="checkbox"/> BACK PAIN |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> NEURITIS | <input type="checkbox"/> POLIO |
| <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> BLOOD VESSEL DISEASE | <input type="checkbox"/> NERVOUSNESS | <input type="checkbox"/> PLEURISY |
| <input type="checkbox"/> COLD SORES | <input type="checkbox"/> LOW BLOOD SUGAR | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> MUMPS |
| <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> MENSTRUAL CRAMPS | <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> MALARIA |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> IRREGULAR PERIODS | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> GOUT |
| <input type="checkbox"/> SINUS | <input type="checkbox"/> THYROID PROBLEM | <input type="checkbox"/> HIV VIRUS | <input type="checkbox"/> MIGRAINES |
| <input type="checkbox"/> SLEEPING PROBLEMS | <input type="checkbox"/> HEPITITIS | <input type="checkbox"/> DIGESTIVE PROBLEMS | <input type="checkbox"/> VERTIGO |
| <input type="checkbox"/> KIDNEY INFECTION | <input type="checkbox"/> U.T.I. | <input type="checkbox"/> HOT FLASHES | <input type="checkbox"/> TWITCHING |

IN PATIENT / OUT PATIENT OPERATIONS AND PROCEDURES-HOSPITALIZATION

DATE	DATE	DATE	DATE
_____ Vaccinations	_____ Rectal Surgery	_____ Thyroid	_____ Tonsillectomy
_____ Tubes in Ears	_____ Stomach	_____ Gall Bladder	_____ Appendectomy
_____ Sinus	_____ Back Operation	_____ Female Organs	_____ Hernia

Hospital Stays _____

Other Surgeries _____

List any accidents or falls/list dates: Car _____ Recreational Vehicle _____ Sports _____
 School _____ Other _____

Lists any broken bones or dislocations _____

Do you suffer from any condition other than that for which you are consulting us? _____

Are you presently taking prescription or over-the-counter medication? Yes No List _____

CONSENT TO X-RAY

Patient Name _____ I hereby authorize Dr. Scott and whomever he designates to take X-Rays of myself (or said minor).

Dated this _____ day of _____, 20____. Signature _____

Signature of Parent or Guardian _____ Witness _____

