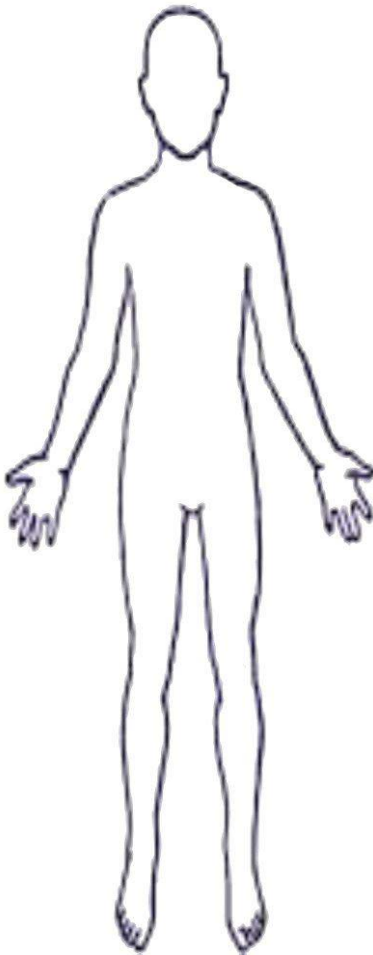


Illnesses/Medical Problems

Check ANY that apply (note: you will list surgery/operations on the next page)



Illness	Details if needed	Date(s) onset
<input type="checkbox"/> Cancer (list involved organ(s))		
<input type="checkbox"/> Depression		
<input type="checkbox"/> Stroke/TIA		
<input type="checkbox"/> Dementia/Alzheimer's		
<input type="checkbox"/> Migraines		
<input type="checkbox"/> Glaucoma		
<input type="checkbox"/> Sinusitis/Rhinitis		
<input type="checkbox"/> Thyroid Problems		
<input type="checkbox"/> Pneumonia/Bronchitis		
<input type="checkbox"/> Asthma		
<input type="checkbox"/> Emphysema		
<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Heart Attack		
<input type="checkbox"/> Atrial Fibrillation		
<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> Heart Failure		
<input type="checkbox"/> High Cholesterol		
<input type="checkbox"/> GERD/Reflux		
<input type="checkbox"/> Hiatal Hernia		
<input type="checkbox"/> Ulcers		
<input type="checkbox"/> Hepatitis/Liver Problems		
<input type="checkbox"/> Kidney Problems		
<input type="checkbox"/> Low Back Pain/Injury		
<input type="checkbox"/> Sciatica		
<input type="checkbox"/> Arthritis (list involved joint(s))		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Anemia		
<input type="checkbox"/> Alcoholism		
<input type="checkbox"/> Eczema		

Other, listed above:

Patient Signature or Initials