| Today's Date:                                                                                                                                                                                                                                                                                                                                                               |                                                                     |                                                                                                       |                                                         |                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| PATIENT DEMOGRAPHICS                                                                                                                                                                                                                                                                                                                                                        |                                                                     |                                                                                                       |                                                         |                                                                                                                                     |
| Name:                                                                                                                                                                                                                                                                                                                                                                       | Birth Date                                                          | e:                                                                                                    | Age:                                                    | Gender:                                                                                                                             |
| Address:                                                                                                                                                                                                                                                                                                                                                                    | City:                                                               |                                                                                                       | _State:                                                 | Zip:                                                                                                                                |
| E-mail Address:                                                                                                                                                                                                                                                                                                                                                             | Mobile Ph                                                           | one                                                                                                   | - Work Pi                                               | hone                                                                                                                                |
| Marital Status: □ Single □ Married □ Widowed                                                                                                                                                                                                                                                                                                                                | Spouse's Na                                                         | ame                                                                                                   |                                                         |                                                                                                                                     |
| Driver's License #                                                                                                                                                                                                                                                                                                                                                          |                                                                     | umber of Children and                                                                                 | Ages:                                                   |                                                                                                                                     |
| Employer:                                                                                                                                                                                                                                                                                                                                                                   |                                                                     |                                                                                                       |                                                         |                                                                                                                                     |
| Name & Number of Emergency Contact:                                                                                                                                                                                                                                                                                                                                         |                                                                     |                                                                                                       | Relations                                               | nlp:                                                                                                                                |
| INSURANCE INFORMATION                                                                                                                                                                                                                                                                                                                                                       |                                                                     |                                                                                                       |                                                         |                                                                                                                                     |
| While health insurance is designed to protect you DO NOT PAY FOR unlimited chiropractic care. NO MAINTENANCE CHIROPRACTIC CARE. O'Dell Fa provide you with an estimation of your out-of-poor provide you with an estimate of cost.                                                                                                                                          | INSURANCE                                                           | COMPANY WILL PAY I                                                                                    | FOR CORF<br>f our ability                               | RECTIVE, REHABILITATIVE OR<br>y, verify your insurance and                                                                          |
| Please provide your insurance information below                                                                                                                                                                                                                                                                                                                             | •                                                                   |                                                                                                       |                                                         |                                                                                                                                     |
| Name of Insurance Company:                                                                                                                                                                                                                                                                                                                                                  |                                                                     | Insured's Date of Birtl                                                                               | h:                                                      |                                                                                                                                     |
| Identification #:                                                                                                                                                                                                                                                                                                                                                           | Group #:                                                            |                                                                                                       |                                                         |                                                                                                                                     |
| Policy Holder's Name and Date of Birth:                                                                                                                                                                                                                                                                                                                                     |                                                                     | Relationship: _                                                                                       |                                                         |                                                                                                                                     |
| ASSIGNMENT OF BENEFITS  I hereby authorize payment to be made directly to healthcare plan or from any other collateral source payment for services rendered. I also authorize a I may be entitled shall be paid directly to O'Dell For and will promptly pay any non-covered service allow O'Dell Family Chiropractic to use their Pathoperations and coordination of care. | ce. Additional<br>and direct that<br>amily Chiropa<br>es, copays ar | ly, I authorize the relea<br>any insurance or med<br>ractic. I understand an<br>ad deductible amounts | ise of any<br>lical cover<br>d agree th<br>s. The patio | information required to secure<br>age benefit payments to which<br>at I am financially responsible<br>ent understands and agrees to |
| Signature:                                                                                                                                                                                                                                                                                                                                                                  |                                                                     | Date:                                                                                                 |                                                         |                                                                                                                                     |

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## **TERMS OF AGREEMENT**

OUR GOAL IS TO CORRECT VERTEBRAL SUBLUXATIONS, WHICH ALLOWS FOR A BETTER EXPRESSION OF HEALTH. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art and does not proclaim to cure or correct any named disease. We do not offer to diagnose or treat any disease or condition other than vertebral subluxations. However, if during the course of chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. By signing below, I agree to the treatment recommended by my chiropractor. I intend this consent form to cover the entire course of treatment for my present condition(s)for which I seek treatment at this facility. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstance.

| extraordinary circumstance.                                                                                                                                                                                                                                              | onsent, to any proposed procedure of anotapeans ceases, accome one general                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| Signature:                                                                                                                                                                                                                                                               | Date:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |    |
| ACKNOWLEDGEMENT OF PRIVAC                                                                                                                                                                                                                                                | PRACTICES                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |    |
| document. The document describe<br>treatment, payment of my bills, or<br>Privacy Practices will be also prov<br>O'Dell Family Chiropractic's duties<br>right to change the privacy practic<br>Privacy Practices by calling the off<br>appointment, or accessing O'Dell I | riew O'Dell Family Chiropractic's Notice of Privacy Practices prior to signing this the types of uses and disclosures of my protected health information that will occur in me the performance of health care operations of O'Dell Family Chiropractic. The Notice of end on request at the front desk of this practice. The document describes my rights and rith respect to my protected health information. O'Dell Family Chiropractic reserves the that are described in the Notice of Privacy Practices. I may obtain a revised Notice of e and requesting a revised copy be sent in the mail, ask for one at time of my next mily Chiropractic's website. I have the right to revoke this consent, in writing, except to actic has taken action in reliance on this consent. | ıy |
| Signature:                                                                                                                                                                                                                                                               | Date:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |    |

| ame Date                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| ame lease describe your MAJOR complaint/Why are you here?:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
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| Vhen did your problem begin? Previous History of this? Yes No When?<br>ow did it begin?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
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| he pain is constant comes and goes. If it comes and goes, how often does the pain exist?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Does it interfere with your   Down   Daily Routine   Recreation   Dother   Dother |
| Vhat makes it better?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| lave you seen another healthcare practitioner for the pain/condition?  Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| If yes, who?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| On the diagram below indicate the type of symptoms you are experiencing right now. Use                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| corresponding symbols. Pain Diagram and Rating                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
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| Please number and mark the severity of pain you are currently please mark on the diagram the location of the experiencing on a scale from 0 (no pain) to 10 (severe pain).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Current pain: /10 0 1 2 3 4 5 6 7 8 9 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Average pain: /10 0 1 2 3 4 5 6 7 8 9 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| (Visual Analog Pain Severity Scale)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Please describe the type of pain or sensation you are currently experiencing. (Check all that apply)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| □ Aching A □ Shooting                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| □ Burning B □ Stabbing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| □ Dull D □ Stiffness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| □ Numb N □ Throbbing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| ☐ Sharp S ☐ Tingling                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| Other, describe it:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| Comments:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
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| Current Height                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| Weight                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Birth Date: Age:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Referred by:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Previous chiropractic? Last visit?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |

| Constitutional    Respiratory                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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                                                                                                                                          | Review of Systems/Health History             | (Indicate if you have these conditions Nov | w or if you've had them in the Past)  Genitourinary |
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| Partique/Low Energy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | □ Ratique/Low Energy □ Rever/Chills □ COPD □ Rever/Chills □ Loss of Appetite  Musculoskeletal □ Arthritis □ Gout □ Joint Replacement □ Joint Replacement □ Joint Stiffness □ Diarrhea □ Joint Replace Heathea □ Joint Replacement □ Joint Replace Pacement □ J | Patigue/Low Energy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <del></del>                                  | •                                          |                                                     |
| Copp                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   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| Diss of Appetite                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       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| Arthritis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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| □ Gout □ Sleep Apnea □ Anemia □ Sleeding Disorders □ Sleeding Disorders □ Digestive □ Blood Clot/DVT □ Joint Stiffness □ Constipation □ Cancer □ Muscle Weakness □ Diarrhea □ Scoliosis □ Gallbladder Issues □ Excessive Bruising □ Scoliosis □ Gallbladder Issues □ Hepatitis □ Excessive Bruising □ Acrei Cardiovascular □ Heartburn/Acid Reflux □ HIV/AIDS □ Aortic Aneurysm □ Liver Problems □ Skin □ Arteriosclerosis □ Nausea/Vomiting □ Acne □ Chest Pain □ Ulcer □ Eczema □ Congestive Heart Failure Neurological □ Hair Loss □ Congestive Heart Failure Neurological □ Hair Loss □ Proinasis | □ Gout □ Sleep Apnea □ Tuberculosis □ Bleeding Disorders □ Indecation: □ Bloed Clot/DVT □ Joint Stiffness □ Digestive □ Blood Clot/DVT □ Joint Stiffness □ Diarrhea type: □ Blood Clot/DVT □ Joint Stiffness □ Diarrhea type: □ Stood Sensitivities □ Excessive Bruising □ Scoliosis □ Gold Sensitivities □ Excessive Bruising □ Scoliosis □ Gallbladder Issues □ Hepatitis □ Heartburn/Acid Reflux □ HIV/AIDS □ Arteriosclerosis □ Road Vomiting □ Acne □ Chest Pain □ Ulcer □ Eczema □ Chest Pain □ Ulcer □ Eczema □ Congestive Heart Failure □ Neurological □ Hair Loss □ Brain Aneurysm □ Psoriasis □ Brain Ane | □ Gout □ Sleep Apnea □ Tuberculosis □ Bleeding Disorders □ Indectation: □ Blood Clot/DVT □ Joint Stiffness □ Digestive □ Blood Clot/DVT □ Joint Stiffness □ Diarrhea type: □ Blood Clot/DVT □ Joint Stiffness □ Diarrhea type: □ Stood Sensitivities □ Excessive Bruising □ Scoliosis □ Gold Sensitivities □ Excessive Bruising □ Scoliosis □ Gallbladder Issues □ Hepatitis □ Heartburn/Acid Reflux □ HIV/AIDS □ Arteriosclerosis □ Nausea/Vomiting □ Acne □ Chest Pain □ Ulcer □ Eczema □ Chest Pain □ Ulcer □ Eczema □ Congestive Heart Failure Neurological □ Hair Loss □ Brain Aneurysm □ Psoriasis □ Brain Aneurysm □ Psoriasis □ Brain Aneurysm □ Psoriasis □ Heart Attack □ Epilepsy/Scizures □ Rashes □ High Cholesterol □ Headaches/Migraines □ Glaucoma □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss □ Blurry Vision □ Pacemaker □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds Other: □ Distribution □ Difficulty Swallowing   MEN'S HEALTH HISTORY  Total number of pregnancles: □ Number of births: □ Date of last menstrual period? □ Painful menstruation? Yes No □ Irregular cycle? Yes No □ Do you take birth control pills? Yes No □ Breast problems? Yes No □ Irregular cycle? Yes No □ Do you take birth control pills? Yes No □ Breast problems? Yes No □ Irregular cycle? Yes No □ Do you take birth control pills? Yes No □ Breast problems? Yes No □ Irregular cycle? Yes No □ Do you take birth control pills? Yes No □ Breast problems? Yes No □ Irregular cycle? Yes No □ Do you take birth control pills? Yes No □ Breast problems? Yes No □ Menopause: Yes No □ Do you take birth control pills? Yes No □ Breast problems? Yes No □ Menopause: Yes No □ Do you take birth control pills? Yes ■ No □ Breast problems? Yes No □ Menopause: Yes No □ No □ You take birth control pills? Yes ■ No □ Pace Problems? Yes ■ No □ Pace Problem |                                              | _                                          |                                                     |
| Oloit Replacement   Digestive   Bleeding Disorders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Gotta   Discreta   D  | Joint Replacement   Juberculosis   Bleeding Disorders                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | □ Arthritis                                  |                                            | <del>-</del>                                        |
| location:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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| Doint Stiffness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Doint Stiffness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Notes   Distributes   Distri  | · -                                          |                                            |                                                     |
| Districts   Dist  | Osteoporosis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | District   Osteoporosis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                              |                                            | <b></b>                                             |
| □ Osteoporosis □ Food Sensitivities □ Excessive Bruising □ Scoliosis □ Galibladder Issues □ Hepatitis □ Acric Aneurysm □ Liver Problems Skim □ Arteriosclerosis □ Nausea/Vomiting □ Acne □ Chest Pain □ Ulcer □ □ Eczema □ Congestive Heart Failure Neurological □ Hair Loss □ Coronary Artery Disease □ Brain Aneurysm □ Psoriasis □ Heart Attack □ Epilepsy/Seizures □ Rashes □ High Blood Pressure □ Head Injury Eyes/Ears/Nose/Throat □ Hregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Psychiatric □ Dizziness □ Blurry Vision □ Pacemaker □ Anxiety Disorders □ Hearing Loss □ Ringing in Ears □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds Other: □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Total number of pregnancles: Number of births: Date of last menstrual period? Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No Painful menstruation? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                          | □ Osteoporosis □ Gallbladder Issues □ Hepatitis □ Scoliosis □ Gallbladder Issues □ Hepatitis □ Hepatitis □ Arctic Aneurysm □ Liver Problems Skim □ Arteriosclerosis □ Nausea/Vomiting □ Acne □ Chest Pain □ Ulcer □ Eczema □ Hair Loss □ Congestive Heart Failure Neurological □ Hair Loss □ Coronary Artery Disease □ Brain Aneurysm □ Psoriasis □ Heart Attack □ Epilepsy/Seizures □ Rashes □ High Blood Pressure □ Head Injury Eyes/Ears/Nose/Throat □ High Blood Pressure □ Head Injury Eyes/Ears/Nose/Throat □ High Cholesterol □ Headaches/Migraines □ Glaucoma □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Dizziness □ Stroke □ Anxiety Disorders □ Dizziness □ Blurry Vision □ Dizziness □ Stroke □ Anxiety Disorders □ Dizziness □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Depression □ Ringing in Ears □ Diabetes □ Thyroid Disorder □ Unusual Stress □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes_ No_  WOMEN'S HEALTH HISTORY  Tostoterone tested/using supplements?  Hair Loss/Thinning? Yes_ No_ Irregular cycle? Yes_ No_ Do you take birth control pills? Yes_ No_  Breast problems? Yes_ No_ Menopause: Yes_ No_ Do you take birth control pills? Yes_ No_                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | □ Osteoporosis □ Food Sensitivities □ Excessive Bruising □ Scoliosis □ Gallbladder Issues □ Hepatitis □ Hepatitis □ Acrdiovascular □ Heartburn/Acid Reflux □ HIV/AIDS □ Acrdiovascular □ Liver Problems Skim □ Atteriosclerosis □ Nausea/Vomiting □ Acne □ Chest Pain □ Ulcer □ Eczema □ Hair Loss □ Congestive Heart Failure Neurological □ Hair Loss □ Coronary Artery Disease □ Brain Aneurysm □ Psoriasis □ Psoriasis □ Heart Attack □ Epilepsy/Seizures □ Rashes □ High Blood Pressure □ Head Injury Eyes/Ears/Nose/Throat □ High Cholesterol □ Headaches/Migraines □ Glaucoma □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss □ Blurry Vision □ Diabetes □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Depression □ Ringing in Ears □ Diabetes □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds □ Difficulty Swallowing   MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No Tostotorone tested/using supplements? □ Date of last menstrual period? □ Palnful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No Breast problems? Yes No Menopause: Yes No Do you take birth control pills? Yes No Menopause: Yes No Menopau | □ Joint Stiffness                            |                                            |                                                     |
| □ Scoliosis □ Gallbladder Issues □ Hepatitis  Cardiovascular □ Heartburn/Acid Reflux □ HIV/AIDS □ Aortic Aneurysm □ Liver Problems Skin □ Arteriosclerosis □ Nausea/Vomiting □ Acne □ Chest Pain □ Ulcer □ Eczema □ Congestive Heart Failure Neurological □ Hair Loss □ Coronary Artery Disease □ Brain Aneurysm □ Psoriasis □ Heart Attack □ Epilepsy/Seizures □ Rashes □ High Blood Pressure □ Head Injury Eyes/Ears/Nose/Throat □ High Cholesterol □ Headaches/Migraines □ Glaucoma □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Depression □ Ringing in Ears □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds Other: □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Hair Loss/Thinning? Yes No □  WOMEN'S HEALTH HISTORY  Total number of pregnancles: □ Number of births: □ Date of last menstrual period? □ Painful menstruation? Yes No □ Irregular cycle? Yes No □ Do you take birth control pills? Yes No □                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | O Scoliosis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | □ Scoliosis □ Gallbladder Issues □ Hepatitis □ HIV/AIDS  Cardiovascular □ Heartburn/Acid Reflux □ HIV/AIDS  □ Aortic Aneurysm □ Liver Problems Skin □ Acne □ Chest Pain □ Ulcer □ Eczema □ Congestive Heart Failure Neurological □ Hair Loss □ Coronary Artery Disease □ Brain Aneurysm □ Psoriasis □ Heart Attack □ Epilepsy/Seizures □ Rashes □ High Blood Pressure □ Head Injury Eyes/Ears/Nose/Throat □ High Cholesterol □ Headaches/Migraines □ Glaucoma □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds Other: □ Unusual Stress □ Frequent Nosebleeds □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Total number of pregnancles: □ Number of births: □ Date of last menstrual period? □ Painful menstruation? Yes No Menopause: Yes No Do you take birth control pills? Yes No Breast problems? Yes No Menopause: Yes No Do you take birth control pills? Yes No Menopause: Yes No  | <ul> <li>Muscle Weakness</li> </ul>          |                                            |                                                     |
| Cardiovascular                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         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                                                                                                                                          | □ Osteoporosis                               |                                            |                                                     |
| □ Aortic Aneurysm □ Liver Problems Skin □ Arteriosclerosis □ Nausea/Vomiting □ Acne □ Chest Pain □ Ulcer □ Eczema □ Congestive Heart Failure Neurological □ Hair Loss □ Coronary Artery Disease □ Brain Aneurysm □ Psoriasis □ Heart Attack □ Epilepsy/Seizures □ Rashes □ High Blood Pressure □ Head Injury Eyes/Ears/Nose/Throat □ High Cholesterol □ Headaches/Migraines □ Glaucoma □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Depression □ Ringing in Ears □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds Other: □ Unusual Stress □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Hair Loss/Thinning? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | O Aortic Aneurysm O Arteriosclerosis O Atreriosclerosis O Chest Pain O Chest Pain O Congestive Heart Failure O Coronary Artery Disease O Heart Attack O Epilepsy/Seizures O Heart Attack O High Blood Pressure O Head Injury O Headaches/Migraines O Irregular Heartbeat O Irregular Heartbeat O Anxiety Disorders O Heart Attack O Epilepsy/Seizures O Head Injury O Headaches/Migraines O Irregular Heartbeat O Multiple Sclerosis O Blurry Vision O Pacemaker O Anxiety Disorders O Hearing Loss Endocrine O Diabetes O Insomnia O Insomnia O Loss of Smell O Thyroid Disorder O Unusual Stress O Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes_ No_  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: O Day ou take birth control pills? Yes_ No_  Breast problems? Yes_ No_ Menopause: Yes_ No_                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | O Actic Aneurysm O Atteriosclerosis O Atteriosclerosis O Chest Pain O Chest Pain O Congestive Heart Failure O Coronary Artery Disease O Heart Attack O Epilepsy/Seizures O Heart Attack O High Blood Pressure O Head Injury O Broizsis O Blurry Vision O Brozemaker O Stroke O Anxiety Disorders O Boursesion O Brozensaker O Brozensaker O Brozensaker O Brozensaker O Brozensaker O Brozensaker O Depression O Diabetes O Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes_ No_  WOMEN'S HEALTH HISTORY  Total number of pregnancles: Number of births: O Day ou take birth control pills? Yes_ No_  Breast problems? Yes_ No_  Menopause: Yes_ No_  Breast problems? Yes_ No_  Menopause: Yes_ No_  Breast problems? Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Breast problems? Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Breast problems? Yes_ No_  Menopause: Yes_ No_  Meno | □ Scoliosis                                  |                                            | •                                                   |
| □ Arteriosclerosis □ Nausea/Vomiting □ Acne □ Chest Pain □ Ulcer □ Eczema □ Congestive Heart Failure Neurological □ Hair Loss □ Coronary Artery Disease □ Brain Aneurysm □ Psoriasis □ Heart Attack □ Epilepsy/Seizures □ Rashes □ High Blood Pressure □ Head Injury Eyes/Ears/Nose/Throat □ High Cholesterol □ Headaches/Migraines □ Glaucoma □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Depression □ Ringing in Ears □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds Other: □ Unusual Stress □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | O Arteriosclerosis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | O Arteriosclerosis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Cardiovascular                               | <ul> <li>Heartburn/Acid Reflux</li> </ul>  | □ HIV/AIDS                                          |
| □ Chest Pain □ Ulcer □ Eczema □ Hair Loss □ Coronary Artery Disease □ Brain Aneurysm □ Psoriasis □ Psoriasis □ Heart Attack □ Epilepsy/Seizures □ Rashes □ High Blood Pressure □ Head Injury Eyes/Ears/Nose/Throat □ High Cholesterol □ Headaches/Migraines □ Glaucoma □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Diabetes □ Dapression □ Ringing in Ears □ Diabetes □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Prequent Nosebleeds □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No Total number of pregnancies: □ Number of births: □ Date of last menstrual period? □ Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No ■                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | □ Chest Pain □ Congestive Heart Failure □ Coronary Artery Disease □ Brain Aneurysm □ Psoriasis □ Heart Attack □ Epilepsy/Seizures □ Rashes □ High Blood Pressure □ Head Injury □ Headaches/Migraines □ High Cholesterol □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Psoriasis □ Blurry Vision □ Psoriasis □ Blurry Vision □ Psoriasis □ Blurry Vision □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Diabetes □ Diabetes □ Diabetes □ Thyroid Disorder □ Diabetes □ Thyroid Disorder □ Unusual Stress □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period? Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | □ Chest Pain □ Congestive Heart Failure □ Coronary Artery Disease □ Brain Aneurysm □ Psoriasis □ Heart Attack □ Epilepsy/Seizures □ Heart Attack □ High Blood Pressure □ Head Injury □ High Cholesterol □ Headaches/Migraines □ Irregular Heartbeat □ Irregular Heartbeat □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Diabetes □ Diabetes □ Diabetes □ Thyroid Disorder □ Diabetes □ Thyroid Disorder □ Unusual Stress □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Hair Loss/Thinning? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No Breast problems? Yes No Menopause: Yes Menopause: Yes No Menopause: Yes No Menopause: Yes No Menopause: Yes No Menopause: Yes Menopaus | □ Aortic Aneurysm                            | <del></del>                                | Skin                                                |
| □ Congestive Heart Failure □ Coronary Artery Disease □ Heart Attack □ Epilepsy/Seizures □ Heart Attack □ High Blood Pressure □ Head Injury □ High Cholesterol □ Headaches/Migraines □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Depression □ Ringing in Ears □ Diabetes □ Thyroid Disorder □ Unusual Stress □ Thyroid Disorder □ Unusual Stress □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No_  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No_ Irregular cycle? Yes No_ Do you take birth control pills? Yes No_                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | □ Congestive Heart Failure □ Coronary Artery Disease □ Heart Attack □ Epilepsy/Seizures □ Heart Attack □ Head Injury □ Head Injury □ High Cholesterol □ Headaches/Migraines □ Irregular Heartbeat □ Pacemaker □ Stroke □ Anxiety Disorders □ Dizziness □ Stroke □ Depression □ Diabetes □ Diabetes □ Diabetes □ Thyroid Disorder □ Thyroid Disorder □ Thyroid Disorder □ Unusual Stress □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Menopause: Yes No Do you take birth control pills? Yes No Breast problems? Yes No Menopause: Ye                  | □ Congestive Heart Failure □ Coronary Artery Disease □ Heart Attack □ Epilepsy/Seizures □ Heart Attack □ Epilepsy/Seizures □ Heart Bilood Pressure □ Head Injury □ High Cholesterol □ Headaches/Migraines □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Stroke □ Anxiety Disorders □ Depression □ Dizziness □ Diabetes □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancles: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Menopause: Yes No  Breast problems? Yes No Menopause: Yes No  Breast problems? Yes No Menopause: Yes No  Breast problems? Yes No Menopause: Yes No  Menor Menopause: Yes No  Breast problems? Yes No Menopause: Yes No  Breast problems? Yes No Menopause: Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | □ Arteriosclerosis                           | □ Nausea/Vomiting                          | □ Acne                                              |
| □ Coronary Artery Disease □ Heart Attack □ Epilepsy/Seizures □ Rashes □ High Blood Pressure □ High Blood Pressure □ Head Injury □ High Cholesterol □ Headaches/Migraines □ Glaucoma □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Depression □ Ringing in Ears □ Diabetes □ Diabetes □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds □ Thyroid Pregnancies: □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | □ Coronary Artery Disease □ Heart Attack □ Epilepsy/Seizures □ Head Injury □ High Blood Pressure □ Head Injury □ Headaches/Migraines □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Stroke □ Anxiety Disorders □ Dizziness □ Stroke □ Dizziness □ Stroke □ Dizziness □ Diabetes □ Diabetes □ Diabetes □ Diabetes □ Thyroid Disorder □ Diabetes □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds Other: □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No  Breast problems? Yes No Menopause: Yes No  Breast problems? Yes No Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | □ Coronary Artery Disease □ Heart Attack □ Epilepsy/Seizures □ Head Injury □ High Blood Pressure □ Head Injury □ Headaches/Migraines □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Stroke □ Anxiety Disorders □ Depression □ Dizziness □ Diabetes □ Diabetes □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Breast problems? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 🗆 Chest Pain                                 |                                            | □ Eczema                                            |
| Heart Attack                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | □ Heart Attack □ High Blood Pressure □ High Cholesterol □ Head Injury □ Head Cholesterol □ Head Injury □ Head Cholesterol □ Head Injury □ Head Cholesterol □ Irregular Heartbeat □ Irregular Heartbeat □ Dizziness □ Stroke □ Anxiety Disorders □ Depression □ Ringing in Ears □ Diabetes □ Diabetes □ Diabetes □ Thyroid Disorder □ Unusual Stress □ Difficulty Swallowing    MEN'S HEALTH HISTORY   Have you had any prostate problems? Yes No   WOMEN'S HEALTH HISTORY   Have you had any prostate problems?   No   WOMEN'S HEALTH HISTORY   Heart HISTORY   Have you had any prostate problems?   No   Women's Health History   Have you had any prostate problems?   No   Women's Health History   Have you had any prostate problems?   No   Women's Health History   Have you had any prostate problems?   No   Women's Health History   Have you had any prostate problems?   No   Women's Health History   Have you had any prostate problems?   No   Women's Health History   Head Injury                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | □ Heart Attack □ High Blood Pressure □ High Cholesterol □ Head Injury □ Head Injury □ High Cholesterol □ Headaches/Migraines □ Irregular Heartbeat □ Irregular Heartbeat □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss □ Blurry Vision □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds □ Difficulty Swallowing    MEN'S HEALTH HISTORY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <ul> <li>Congestive Heart Failure</li> </ul> | Neurological                               | □ Hair Loss                                         |
| Heart Attack                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | □ Heart Attack □ High Blood Pressure □ Headaches/Migraines □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss  Endocrine □ Depression □ Ringing in Ears □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  WOMEN'S HEALTH HISTORY  Tostoterone tested/using supplements?  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No kregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No  Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | □ Heart Attack □ High Blood Pressure □ Headaches/Migraines □ Blurry Vision □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss □ Diabetes □ Diabetes □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No_  Testoterone tested/using supplements? □ Hair Loss/Thinning? Yes No_  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period? □ Painful menstruation? Yes No Menopause: Yes No_ Do you take birth control pills? Yes No_  Breast problems? Yes No Menopause: Yes No_                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | □ Coronary Artery Disease                    | ☐ Brain Aneurysm                           | □ Psoriasis                                         |
| High Cholesterol                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | □ High Cholesterol □ Headaches/Migraines □ Glaucoma □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Depression □ Ringing in Ears □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds Other: □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No_  Testoterone tested/using supplements? □ No_  WOMEN'S HEALTH HISTORY  Total number of pregnancies: □ Number of births: □ Date of last menstrual period? □ Painful menstruation? Yes No_ Irregular cycle? Yes No_ Do you take birth control pills? Yes No_  Breast problems? Yes No_ Menopause: Yes No_                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | □ High Cholesterol □ Headaches/Migraines □ Glaucoma □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Depression □ Ringing in Ears □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds Other: □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No_  Testoterone tested/using supplements? □ No_  WOMEN'S HEALTH HISTORY  Total number of pregnancies: □ Number of births: □ Date of last menstrual period? □ Painful menstruation? Yes No_ Irregular cycle? Yes No_ Do you take birth control pills? Yes No_  Breast problems? Yes No_ Menopause: Yes No_                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                              | □ Epilepsy/Seizures                        | □ Rashes                                            |
| □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss  Endocrine □ Depression □ Ringing in Ears □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds Other: □ □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No No  Testoterone tested/using supplements? □ No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Depression □ Ringing in Ears □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancles: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Depression □ Ringing in Ears □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Inficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancles: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | □ High Blood Pressure                        | □ Head Injury                              | Eyes/Ears/Nose/Throat                               |
| □ Irregular Heartbeat □ Multiple Sclerosis □ Blurry Vision □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Depression □ Ringing in Ears □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds Other: □ □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | □ Irregular Heartbeat □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Diabetes □ Diabetes □ Thyroid Disorder □ Unusual Stress □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements? Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No  Breast problems? Yes No Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No  Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | □ Irregular Heartbeat □ Pacemaker □ Psychiatric □ Dizziness □ Stroke □ Anxiety Disorders □ Hearing Loss Endocrine □ Diabetes □ Diabetes □ Thyroid Disorder □ Unusual Stress □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements? Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | ☐ High Cholesterol                           | ☐ Headaches/Migraines                      | Glaucoma                                            |
| □ Pacemaker                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Pacemaker Psychiatric Dizziness Stroke Anxiety Disorders Hearing Loss Endocrine Depression Ringing in Ears Diabetes Disorder Disorder Disorder Disorder Disorder Disorder Disorder Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes_ No_  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes_ No_  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes_ No_ Irregular cycle? Yes_ No_ Do you take birth control pills? Yes_ No_  Breast problems? Yes_ No_ Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Pacemaker Psychiatric Dizziness Stroke Anxiety Disorders Hearing Loss Endocrine Dizbetes Disorder Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes_ No_  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes_ No_  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes_ No_ Irregular cycle? Yes_ No_ Do you take birth control pills? Yes_ No_  Breast problems? Yes_ No_ Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes_ No_  Menopause: Yes               |                                              | Multiple Sclerosis                         | □ Blurry Vision                                     |
| □ Stroke □ Anxiety Disorders □ Hearing Loss  Endocrine □ Depression □ Ringing in Ears □ Diabetes □ Insomnia □ Loss of Smell □ Thyroid Disorder □ Unusual Stress □ Frequent Nosebleeds Other: □ Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No_  Testoterone tested/using supplements? □ No_  WOMEN'S HEALTH HISTORY  Total number of pregnancies: □ Number of births: □ Date of last menstrual period? □ Painful menstruation? Yes No_ Irregular cycle? Yes No_ Do you take birth control pills? Yes No_                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | □ Stroke □ Depression □ Diabetes □ Diabetes □ Thyroid Disorder □ Unusual Stress □ Difficulty Swallowing  ■ MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  — WOMEN'S HEALTH HISTORY  Total number of pregnancles: Number of births: Date of last menstrual period?  — Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Stroke                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                              | Psychiatric                                | □ Dizziness                                         |
| Endocrine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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                                                                                                                                          | □ Stroke                                     |                                            | ☐ Hearing Loss                                      |
| Diabetes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Diabetes   Insomnia   Loss of Smell   Thyroid Disorder   Unusual Stress   Frequent Nosebleeds   Difficulty Swallowing    MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancles: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Diabetes   Insomnia   Loss of Smell   Thyroid Disorder   Unusual Stress   Frequent Nosebleeds   Difficulty Swallowing    MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancles: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Endocrine                                    |                                            |                                                     |
| Other: Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancles: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Thyroid Disorder Unusual Stress Frequent Nosebleeds Other: Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Thyroid Disorder Unusual Stress Frequent Nosebleeds Other: Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                              |                                            |                                                     |
| Other: Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Other: Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Other: a Difficulty Swallowing  MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                              | _ ****                                     |                                                     |
| MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | MEN'S HEALTH HISTORY  Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | •                                            | 2 0                                        |                                                     |
| Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No irregular cycle? Yes No Do you take birth control pills? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Have you had any prostate problems? Yes No  Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                              |                                            |                                                     |
| Testoterone tested/using supplements?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Testoterone tested/using supplements?  Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | MEN'S HEALTH HISTORY                         |                                            |                                                     |
| Hair Loss/Thinning? Yes No  WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Have you had any prostate problems? Yes_     | _ No                                       |                                                     |
| WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No trregular cycle? Yes No Do you take birth control pills? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | WOMEN'S HEALTH HISTORY  Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Testoterone tested/using supplements?        |                                            |                                                     |
| Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Total number of pregnancies: Number of births: Date of last menstrual period?  Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Hair Loss/Thinning? Yes No                   |                                            |                                                     |
| Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Painful menstruation? Yes No Irregular cycle? Yes No Do you take birth control pills? Yes No  Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | WOMEN'S HEALTH HISTORY                       |                                            |                                                     |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Total number of pregnancies: Numi            | per of births: Date of last men            | strual period?                                      |
| Breast problems? Yes No Menopause: Yes No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 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                                                                                                                       | Painful menstruation? Yes No Irregul         | ar cycle? Yes No Do you take bi            | rth control pills? Yes No                           |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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## **SURGERIES AND ACCIDENTS**

| Surgery/Hospitalization                     | Date                   | Reason/Diagnosis                               |         |
|---------------------------------------------|------------------------|------------------------------------------------|---------|
| Accidents/Injuries Fractured/Broken be      | one Injured in an      | accident Been knocked unconscious Had a sprain | /strair |
| GENERAL HISTORY                             |                        |                                                | •       |
| How would you rate your diet? Good Fa       | alr Poor               |                                                |         |
| Water: Approx. how many ounces per day?     |                        |                                                | _       |
| Exercise: Yes No Activity                   |                        |                                                | _       |
| Stretch: Yes No How often                   |                        |                                                |         |
| Sleep: Side Back Elevated Sto               | mach Chair             | CPAP                                           |         |
| Stress Level: 1 2 3 4 5                     | 6 7 8                  | 9 10                                           |         |
| Hobbies/ Sports:                            |                        |                                                | _       |
| Work: Full Time Part Time School            | Retired Disa           | bility Other                                   | _       |
| Postion                                     | _ Description          |                                                |         |
| Medications (Please include both pres       | scriptions and over-th | e-counter medications)                         | _       |
|                                             |                        |                                                | -<br>-  |
| Vitamins/Supplements                        |                        |                                                |         |
| SOCIAL HISTORY                              |                        |                                                |         |
| Do you drink alcohol on a regular basis? Yo | es No Servings         | per day                                        |         |
| Do you smoke or use tobacco products/vap    | e/marijuana? Yes       | No How much?                                   |         |
| Have you smoked in the past? Yes No_        | _ When did you quit    |                                                |         |
| Do you consume caffeine daily? Yes No       | How much?              |                                                |         |
| FAMILY HISTORY                              |                        |                                                |         |
| Relationship Age (if living)                | dedical Conditions     |                                                |         |
| Mother                                      |                        |                                                |         |
| Father                                      |                        |                                                |         |
|                                             |                        |                                                | 7       |
| Patient or Authorized Person S              | ignature               |                                                |         |
|                                             | Date                   |                                                |         |

O'Dell Family Chiropractic

28245 Southfield Rd. Lathrup Village, MI 48076 248-552-1110 www.odelifamilychiropractic.com