			General Health				Eye Ear Nose Throat
N/A	Past	Present		N/A	Past	Present	•
O	\mathbf{O}	•	Insomnia	O	O	O	Bleeding Gums
O	\mathbf{O}	•	Chills	O	O	O	Blurred/Double Vision
O	\mathbf{O}	•	Dizziness/Faintness	O	O	O	Difficulty Swallowing
O	\mathbf{O}	O	Fever	O	O	O	Earache
O	\mathbf{O}	O	Weight Loss	O	O	O	Loss of Hearing
\mathbf{O}	\mathbf{O}	0	Numbness	\mathbf{O}	\mathbf{O}	\mathbf{O}	Nosebleeds
\mathbf{O}	\mathbf{O}	0	Sweats	\mathbf{O}	\mathbf{O}	\mathbf{O}	Persistent Cough
•	\mathbf{O}	0	Joint Pain/Weakness	•	\mathbf{O}	\mathbf{O}	Ringing in Ears
•	\mathbf{O}	0	Bone Pain	•	\mathbf{O}	\mathbf{O}	Sinus Problems/Infections
•	\mathbf{O}	0	Joint Pain	•	\mathbf{O}	\mathbf{O}	Halos/Flashes in Vision
O	\mathbf{O}	0	Blood in Urine	O	0	•	Macular Degeneration
•	\mathbf{O}	0	Frequent Urination	•	O	O	Glaucoma
•	\mathbf{O}	0	Painful Urination				
\mathbf{O}	\mathbf{O}	O	Shortness of Breath				Skin
\mathbf{O}	\mathbf{O}	O	Cough	•	\mathbf{O}	\mathbf{O}	Shingles
\mathbf{O}	\mathbf{O}	O	Other	•	\mathbf{O}	\mathbf{O}	Bruise Easily
				•	O	\mathbf{O}	Hives
			Gastrointestinal	O	\mathbf{O}	•	Itching/Rashes
\mathbf{O}	\mathbf{O}	\mathbf{O}	Poor Appetite	\mathbf{O}	\mathbf{O}	•	Sores that won't heal
\mathbf{O}	\mathbf{O}	\mathbf{O}	Bloating	\mathbf{O}	\mathbf{O}	•	Dry Skin
\mathbf{O}	\mathbf{O}	•	Constipation/Diarrhea	O	•	\mathbf{O}	Other
\mathbf{O}	\mathbf{O}	\mathbf{O}	Change in Bowels				
O	\mathbf{O}	O	Excessive Thirst				Infectious Disease
O	\mathbf{O}	•	Flatulence/Gas	O	O	O	HIV/AIDS
\mathbf{O}	\mathbf{O}	•	Hemorrhoids	O	•	\mathbf{O}	Chicken Pox
\mathbf{O}	\mathbf{O}	•	Indigestion	O	•	\mathbf{O}	Hepatitis
\mathbf{O}	\mathbf{O}	O	Nausea	O	•	O	Herpes
\circ	\mathbf{O}	•	Rectal Bleeding	O	•	•	Measles
\mathbf{O}	\mathbf{O}	\mathbf{O}	Stomach Pain	\mathbf{O}	\mathbf{O}	•	Mumps
\mathbf{O}	\mathbf{O}	•	Vomiting	O	•	\mathbf{O}	Pneumonia
\mathbf{O}	\mathbf{O}	\mathbf{O}	Blood in Vomit	\mathbf{O}	\mathbf{O}	•	Polio
\mathbf{O}	\mathbf{O}	•	Eating Disorder	O	•	\mathbf{O}	Rheumatic Fever
\mathbf{O}	\mathbf{O}	\mathbf{O}	Other	\mathbf{O}	\mathbf{O}	•	Scarlet Fever
				•	\mathbf{O}	\mathbf{O}	Tuberculosis
			Cardiovascular	O	O	O	STDs
O	\mathbf{O}	0	Chest Pain	O	•	•	Meningitis
\mathbf{O}	\mathbf{O}	•	Low Blood Pressure	•	•	O	Other
O	\mathbf{O}	•	High Blood Pressure				Men Only
0	0	O	Irregular Heart Beat	O	•	•	Erectile Dysfunction
Ö	Ö	Ö	Poor Circulation	Ö	Ö	Ö	Abnormal Prostate
O	O	O	Swelling in Ankles	O	0	O	Low Levels of Testosterone
O	O	O	Varicose Veins	O	0	O	Testicular Abnormalities
O	O	O	Neuropathy	O	0	•	Erectile Dysfunction
\mathbf{O}	O	O	Other	O	•	•	Other

			Women Only				Health Habits
N/A	Past	Present		N/A	Past	Present	
0	•	O	Abnormal Pap Smear	O	O	O	Caffeine Type
\mathbf{O}	•	•	Abnormal Bleeding	O	O	O	Amount
\mathbf{O}	•	•	Lump in Breast	O	O	O	Tobacco Type
0	•	O	Menstrual Cramps	O	O	O	Amount
0	•	O	Hot Flashes	O	O	O	Abuse of Prescription Drugs
0	•	O	Currently Pregnant	O	O	O	Nicotine Type
0	•	O	# of pregnancies	O	O	O	Alcohol Amount
\mathbf{O}	•	•	PMS	O	O	O	Inhalants
\mathbf{O}	0	•	Menopause	O	\mathbf{O}	\mathbf{O}	Other
0	•	O	Female Orgasmic Disorder				
\mathbf{O}	\mathbf{O}	O	Other				
			Environmental				
\mathbf{O}	•	•	Exposure to Toxins				
\mathbf{O}	•	•	Exposure to Radiation				
			Disease/Infection				
0	O	•	Parkinson's Disease				
\mathbf{O}	O	0	Fibromyalgia				
\mathbf{O}	O	•	Appendicitis				
0	O	0	Arthritis				
0	O	•	Asthma				
\mathbf{O}	O	0	Bleeding Disorders				
\mathbf{O}	O	•	Cancer				
\mathbf{O}	O	•	Chemical Dependency				
0	0	•	Tic Disorder				
0	O	•	Diabetes				
\mathbf{O}	O	•	Epilepsy				
0	O	•	Heart Disease				
0	O	•	High Cholesterol				
0	0	•	Kidney Disease				
0	O	•	Liver Disease				
0	0	•	Migraines				
0	O	•	Multiple Sclerosis				
0	O	•	Stroke				
0	O	•	Thyroid Problems				
0	O	•	Ulcers				
0	O	•	Cerebral Palsy				
0	O	•	Seizure Disorder				
\mathbf{O}	0	•	Other				

List the medication you are currently taking to include dosage
List ALL allergies to environment, medication, animal, food, and substance
List medications you have taken in the past and if they worked for you or not
Data of Last Physical
Date of Last Physical Physician(s) Current Medical Concerns
List all Surgeries, Accidents, or Trauma to include approximate date
Past medical conditions to include treating physician and outcomes
List ALL occasions when you experienced a concussion or traumatic brain injury
Who was the treating physician?
List any occasion where you experienced trauma to the neck or back
Other health concerns or issues

Biological Family Medical History

Father	Living or Deceased	If deceased, state cause and age _	
	Present Health Problems		
	Hospitalizations		
Mother	Living or Deceased	If deceased, state cause and age _	
	Present Health Problems		
	Hospitalizations		
Maternal Grandfather	Living or Deceased	If deceased, state cause and age _	
	Present Health Problems		
Maternal Grandmother			
	Present Health Problems		
Paternal Grandfather	Living or Deceased	If deceased, state cause and age _	
	Present Health Problems		
Paternal Grandmother	Living or Deceased	If deceased, state cause and age _	
	Present Health Problems		
	Hospitalizations		
Siblings with Health Cond			
Please note here any oth	er biological relatives with s	significant health concerns/probler	ns

Please understand: If it is reported to any PAS clinical or support staff that you have an infectious disease that your physician or care provider(s) does not know about, PAS is required by law to report it to our Local Health Department. Also, if it is reported that you have an infectious disease and are participating in activities that may unknowingly infect another person or persons, PAS is also required by law to report to local health department and law enforcement.

If you have a contagious illness/disease, please let us know so that we may provide a safe place for you to wait outside of the general waiting room area as not to infect other individuals.

THIS FORM IS PART OF THE COMPREHENSIVE DIAGNOSTIC ASSESSMENT USED TO GLEAN PERTINENT MEDICAL INFORMATION.