

**Registration Form**

**Patient Information:**

First Name : \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Apt.: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SS#: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Email Address :** \_\_\_\_\_

**Doctor Information:**

Referring Doctor (who wrote the RX for Physical Therapy): \_\_\_\_\_  
Referring Doctor Address: \_\_\_\_\_  
Referring Doctor Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Primary Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**Insurance Information: Primary Insurance / Secondary Insurance**

1) **Insurance Co:** \_\_\_\_\_ **Ins. ID#:** \_\_\_\_\_  
Is this the Patient's insurance?  YES  NO -If no, the name of the insured: \_\_\_\_\_  
Insured DOB: \_\_\_\_\_ SS# \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
2) **Insurance Co:** \_\_\_\_\_ **Ins. ID#:** \_\_\_\_\_  
is this the Patient's insurance?  YES  NO- If no, the name of the insured: \_\_\_\_\_  
Insured DOB: \_\_\_\_\_ SS# \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Accident Information: Complete this section for Workers Comp or Auto Accident ONLY**

Is this work related? \_\_\_\_\_ Auto Accident? \_\_\_\_\_ Date of the accident: \_\_\_\_\_  
Have you had surgery:  YES  NO Date of surgery: \_\_\_\_\_ Body Part: \_\_\_\_\_  
is there an attorney? Name / Firm: \_\_\_\_\_  
Attorney address: \_\_\_\_\_ Phone: \_\_\_\_\_  
NF/WC Insurance Carrier: \_\_\_\_\_  
Claim Number: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Adjuster Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Assignment of benefits:** I assign my selected Physical Therapy provider to all my rights and benefits under any/all insurance carrier payments for any/ all services rendered. I also authorize all information regarding my benefits and claims submitted by my physical therapy provider on my behalf for services rendered to me. I authorize consent direct payment of any/all insurance carriers listed to make payment directly to the provider. This assignment has been explained to my full understanding and I sign this document willingly and voluntarily.

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient signature: \_\_\_\_\_

**CONSENTS**

**(I) PATIENT AUTHORIZATION TO BE TREATED AND TO SUBMIT MEDICAL CLAIMS**

I authorize payment to from my insurance for all physical therapy services rendered. I also understand and agree regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I consent to be assessed by and to receive treatment from my selected physical therapy provider. I confirm that I have been informed and have participated in planning the care and procedure(s) during my treatment program. I confirm that I signed this consent willingly and voluntarily.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I consent to the release of information and/or disclosure to my physical therapy provider of all or any part of my medical record to other health care providers involved in my care or third party payers as is necessary for processing claims.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**(II) CONSENT TO RELEASE INFORMATION TO FAMILY OR FRIENDS**

Discussion of medical records or billing information would not be disclosed to anyone but yourself over the phone. However, with your consent, our staff will speak with your significant other, close family member or other designated individual. Please understand that you are waiving your right to confidentiality if this consent is given.

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

\_\_\_\_\_ **INITIAL HERE TO GIVE CONSENT**

**(III) Acknowledgement of Privacy Practice Notice**

I have received a copy of the Notice of Privacy Practices from my selected Physical Therapy practice.

**INITIAL HERE FOR ACKNOWLEDGEMENT** \_\_\_\_\_

I have read and understood the above material.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parental signature for Minor:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I am hereby consent to treatment procedures and patient care which in the judgment of my therapist and or, physician, may be considered necessary or advisable while a patient of physical therapy.

## **NO SHOW & CANCELLATION POLICY**

As a courtesy to other patients, as well as the Physical Therapy staff, we would appreciate a call of notification to cancel appointments at least 24 hours prior to your scheduled appointment. Please make sure to reschedule your appointment after cancelling. If a no call is received/documentated your visit will be counted as a “NO SHOW.”

In reference to missing or not showing to your scheduled appointment without prior notification, a fee of \$25 will be collected upon your next visit. Hopefully, this policy will ensure better scheduling availability as to not block appointments for other patients. Should there be any misunderstandings or miscommunications regarding your scheduled appointment, please speak to our office manager.

We thank you in advance for your cooperation.

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

# Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

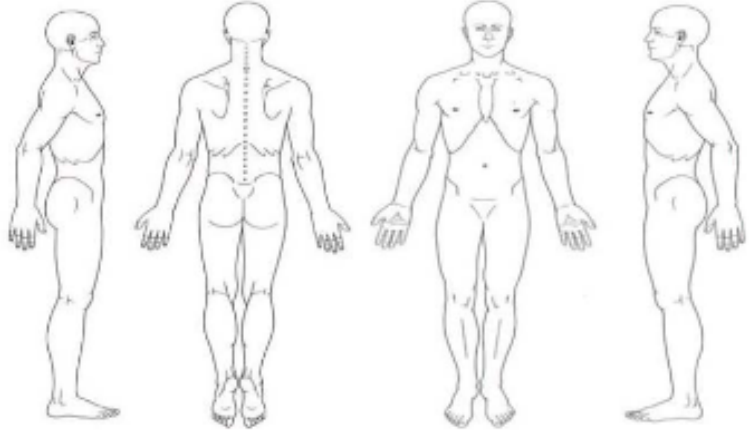
1. Describe your symptoms \_\_\_\_\_

a. When did your symptoms start? \_\_\_\_\_

b. How did your symptoms begin? \_\_\_\_\_

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp      ④ Shooting
- ② Dull ache    ⑤ Burning
- ③ Numb       ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None      ①      ②      ③      ④      ⑤      ⑥      ⑦      ⑧      ⑨      Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

- ① Not at all      ② A little bit      ③ Moderately      ④ Quite a bit      ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? (like visiting with friends, relatives, etc)

- ① All of the time      ② Most of the time      ③ Some of the time      ④ A little of the time      ⑤ None of the time

7. In general would you say your overall health right now is...

- ① Excellent      ② Very Good      ③ Good      ④ Fair      ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One      ③ Medical Doctor      ⑤ Other
- ② Chiropractor      ④ Physical Therapist

a. What treatment did you receive and when?

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays      date: \_\_\_\_\_      ③ CT Scan      date: \_\_\_\_\_
- ② MRI      date: \_\_\_\_\_      ④ Other      date: \_\_\_\_\_

9. Have you had similar symptoms in the past?

- ① Yes      ② No
- ③ Medical Doctor      ⑤ Other
- ④ Physical Therapist

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

10. What is your occupation?

- ① Professional/Executive      ④ Laborer      ⑦ Retired
- ② White Collar/Secretarial      ⑤ Homemaker      ⑧ Other
- ③ Tradesperson      ⑥ FT Student

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time      ③ Self-employed      ⑤ Off work
- ② Part-time      ④ Unemployed      ⑥ Other

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**Patient Health Questionnaire - page 2**

ACN Group, Inc. PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**What type of regular exercise do you perform?**      ① None      ② Light      ③ Moderate      ④ Strenuous

**What is your height and weight?**      Height         Weight    lbs.  
Foot      Inches

**For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.**

- |  |                          |                              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
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| <table border="0" style="width: 100%;"> <tr><td style="width: 10%;"><b>Past</b></td><td style="width: 10%;"><b>Present</b></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Headaches</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Neck Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Upper Back Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Mid Back Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Low Back Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Shoulder Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Elbow/Upper Arm Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Wrist Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hand Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hip/Upper Leg Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Knee/Lower Leg Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ankle/Foot Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Jaw Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Joint Swelling/Stiffness</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Rheumatoid Arthritis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>General Fatigue</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Muscular Incoordination</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Visual Disturbances</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dizziness</td></tr> </table> | <b>Past</b>              | <b>Present</b>               |  | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | Neck Pain | <input type="checkbox"/> | <input type="checkbox"/> | Upper Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Mid Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Low Back Pain | <input type="checkbox"/> | <input type="checkbox"/> | Shoulder Pain | <input type="checkbox"/> | <input type="checkbox"/> | Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> | Wrist Pain | <input type="checkbox"/> | <input type="checkbox"/> | Hand Pain | <input type="checkbox"/> | <input type="checkbox"/> | Hip/Upper Leg Pain | <input type="checkbox"/> | <input 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type="checkbox"/></td><td>Heart Attack</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chest Pains</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Stroke</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Angina</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Kidney Stones</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Kidney Disorders</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Bladder Infection</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Painful Urination</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Loss of Bladder Control</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Prostate Problems</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abnormal Weight Gain/Loss</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Loss of Appetite</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Abdominal Pain</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Ulcer</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hepatitis</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Liver/Gall Bladder Disorder</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Cancer</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Tumor</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Asthma</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Chronic Sinusitis</td></tr> </table> | <b>Past</b> | <b>Present</b> |  | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Stones | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disorders | <input type="checkbox"/> | <input type="checkbox"/> | Bladder Infection | <input type="checkbox"/> | <input type="checkbox"/> | Painful Urination | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Bladder Control | <input type="checkbox"/> | <input type="checkbox"/> | Prostate Problems | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal Weight Gain/Loss | <input type="checkbox"/> | <input type="checkbox"/> | Loss of Appetite | <input type="checkbox"/> | <input type="checkbox"/> | Abdominal Pain | <input type="checkbox"/> | <input type="checkbox"/> | Ulcer | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | Liver/Gall Bladder Disorder | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Tumor | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis | <table border="0" style="width: 100%;"> <tr><td style="width: 10%;"><b>Past</b></td><td style="width: 10%;"><b>Present</b></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Diabetes</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Excessive Thirst</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Frequent Urination</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Smoking/Use Tobacco Products</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Drug/Alcohol Dependence</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Allergies</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Depression</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Systemic Lupus</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Epilepsy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Dermatitis/Eczema/Rash</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>HIV/AIDS</td></tr> <tr><td colspan="3"><b>Females Only</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Birth Control Pills</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Hormonal Replacement</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td>Pregnancy</td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td colspan="3"><b>Other Health Problems/Issues</b></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> <tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td></td></tr> </table> | <b>Past</b> | <b>Present</b> |  | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Thirst | <input type="checkbox"/> | <input type="checkbox"/> | Frequent Urination | <input type="checkbox"/> | <input type="checkbox"/> | Smoking/Use Tobacco Products | <input type="checkbox"/> | <input type="checkbox"/> | Drug/Alcohol Dependence | <input type="checkbox"/> | <input type="checkbox"/> | Allergies | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | Dermatitis/Eczema/Rash | <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS | <b>Females Only</b> |  |  | <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills | <input type="checkbox"/> | <input type="checkbox"/> | Hormonal Replacement | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |  | <b>Other Health Problems/Issues</b> |  |  | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |  | <input type="checkbox"/> | <input type="checkbox"/> |  |
| <b>Past</b>  | <b>Present</b>           |                              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Headaches                    |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Neck Pain                    |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Upper Back Pain              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Mid Back Pain                |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Low Back Pain                |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Shoulder Pain                |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Elbow/Upper Arm Pain         |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Wrist Pain                   |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Hand Pain                    |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Hip/Upper Leg Pain           |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Knee/Lower Leg Pain          |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Ankle/Foot Pain              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Jaw Pain                     |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Joint Swelling/Stiffness     |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Arthritis                    |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Rheumatoid Arthritis         |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | General Fatigue              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Muscular Incoordination      |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Visual Disturbances          |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Dizziness                    |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <b>Past</b>  | <b>Present</b>           |                              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | High Blood Pressure          |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Heart Attack                 |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Chest Pains                  |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Stroke                       |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Angina                       |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Kidney Stones                |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Kidney Disorders             |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Bladder Infection            |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Painful Urination            |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Loss of Bladder Control      |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Prostate Problems            |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Abnormal Weight Gain/Loss    |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Loss of Appetite             |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Abdominal Pain               |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Ulcer                        |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Hepatitis                    |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Liver/Gall Bladder Disorder  |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Cancer                       |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Tumor                        |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Asthma                       |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Chronic Sinusitis            |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <b>Past</b>  | <b>Present</b>           |                              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Diabetes                     |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Excessive Thirst             |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Frequent Urination           |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Smoking/Use Tobacco Products |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Drug/Alcohol Dependence      |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Allergies                    |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Depression                   |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Systemic Lupus               |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Epilepsy                     |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Dermatitis/Eczema/Rash       |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | HIV/AIDS                     |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <b>Females Only</b>  |                          |                              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Birth Control Pills          |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Hormonal Replacement         |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> | Pregnancy                    |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> |                              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <b>Other Health Problems/Issues</b>  |                          |                              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> |                              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> |                              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |
| <input type="checkbox"/>   | <input type="checkbox"/> |                              |  |                          |                          |           |                          |                          |           |                          |                          |                 |                          |                          |               |                          |                          |               |                          |                          |               |                          |                          |                      |                          |                          |            |                          |                          |           |                          |                          |                    |                          |                          |                     |                          |                          |                 |                          |                          |          |                          |                          |                          |                          |                          |           |                          |                          |                      |                          |                          |                 |                          |                          |                         |                          |                          |                     |                          |                          |           |  |             |                |  |                          |                          |                     |                          |                          |              |                          |                          |             |                          |                          |        |                          |                          |        |                          |                          |               |                          |                          |                  |                          |                          |                   |                          |                          |                   |                          |                          |                         |                          |                          |                   |                          |                          |                           |                          |                          |                  |                          |                          |                |                          |                          |       |                          |                          |           |                          |                          |                             |                          |                          |        |                          |                          |       |                          |                          |        |                          |                          |                   |  |             |                |  |                          |                          |          |                          |                          |                  |                          |                          |                    |                          |                          |                              |                          |                          |                         |                          |                          |           |                          |                          |            |                          |                          |                |                          |                          |          |                          |                          |                        |                          |                          |          |                     |  |  |                          |                          |                     |                          |                          |                      |                          |                          |           |                          |                          |  |                                     |  |  |                          |                          |  |                          |                          |  |                          |                          |  |

**Indicate if an immediate family member has had any of the following:**  
 Rheumatoid Arthritis     Heart Problems     Diabetes     Cancer     Lupus     \_\_\_\_\_

**List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:**  
\_\_\_\_\_  
\_\_\_\_\_

**List all the surgical procedures you have had and times you have been hospitalized:**  
\_\_\_\_\_  
\_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Doctor's Additional Comments**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Doctors Signature** \_\_\_\_\_ **Date** \_\_\_\_\_