PATIENT MEDICAL HISTORY CONTINUED (Please circle YES or NO for the following)								
Abdominal Problems	YES	NO	Diabetes	YES	NO	Menstrual Problems	YES	NO
Anesthesia Problems	YES	NO	Esophagitis	YES	NO	Muscle Disease	YES	NO
Asthma	YES	NO	Eye Disease	YES	NO	Neurological Disease	YES	NO
Bleeding Problems	YES	NO	Gerd	YES	NO	Psychiatric Disease	YES	NO
Blood Clots	YES	NO	GI Disease	YES	NO	Significant Weight Change	YES	NO
Bowel Problems	YES	NO	Good Health	YES	NO	STD	YES	NO
Breast Lumps/ Pain	YES	NO	Heart Disease	YES	NO	Stroke	YES	NO
Bronchitis	YES	NO	Hepatitis	YES	NO	TB	YES	NO
Cancer	YES	NO	HIV/ AIDS	YES	NO	Trouble Walking	YES	NO
Cataracts	YES	NO	Hormone Abnormalities	YES	NO	Thyroid Disease	YES	NO
Convulsions/Seizures	YES	NO	Hypertension	YES	NO	Wound Healing Problems	YES	NO
Coronary Artery Disease	YES	NO	Kidney Stones/Disease	YES	NO			
Depression	YES	NO	Lung Disease	YES	NO			