YNC
YOUR NUTRITION CONDITION

Medical History Questionnaire

Date _____ Name _____

Date of Birth _____ Gender _____

Address _____

Phone _____ Email _____

Referred By _____

Indicate the health conditions that you or your relatives have or have had:

1=past 2=current 3=both

	Alzheimers	Arthritis		Asthma	Cancer	Diabetes Type I/II	Epilepsy	Glaucoma	Gout	Hypertension	Hypo/hyperthyroid	Kidney Stones	Neurobiological	Stomach Ulcer	Periodontal	Osteoporosis	Obesity	Heart Attack/Stroke
You																		
Mother																		
Father																		
Brothers																		
Sisters																		
Spouse																		
Children																		
Maternal Grandparents																		
Paternal Grandparents																		

	Abscesses		Celiac Disease		Fibromyalgia		Lyme Disease
	Acne		Cholesterol-High LDL or Low HDL		Flatulence (gas)		Multiple Sclerosis
	ADD/ADHD		Chronic Fatigue Syndrome		Fungal Infections		Nausea-chronic
	Adrenal (Hypo/hyper)		Cirrhosis		Gall Bladder Issues		Nervousness
	AIDS		Cold Feet/Hands		Gastric Ulcer/Gastritis		Numbness
	Alcoholism		Colitis		Genital-Urinary Infection		Parkinson's Disease
	Allergies/Hay Fever		Constipation		GERD/Indigestion		PMS
	Hair Loss		Crohn's Disease		Gingivitis/Bleeding Gums		Pneumonia
	Anemia		Cystitis		Goiter		Psoriasis
	Anxiety		Depression		Headache/Migraines		Seizures
	Appetite (reduced/increased)		Dermatitis/hives/ rashes		Hemorrhoids		Tinnitus (ringing in ears)
	Arrhythmia		Diarrhea		Hernia		Triglycerides-high
	Arteriosclerosis		Diverticulosis/litis		Herpes/Cold Sores		Varicose Veins
	Bacterial infection		Drug Addiction		Hot Flashes		Vertigo
	Bad breath		Dry Skin		Hypoglycemia		Yeast
	Bell's Palsy		Ear Infections		Infection		
	Benign Breast Tumor		Eating Disorder		Insomnia		
	Benign Prostatic Hyperplasia		Eczema		Lactose Intolerance		
	Bipolar Disorder		Epstein Barr Virus		Liver Disease		
	Bronchitis/persistent cough		Eye Disease/ Vision Issues		Low Blood Pressure		
	Bruxism (Grinding Teeth)		Fainting/Dizzy Spells		Lung Problems		