8. Have you ever had hepatitis? (date) _____ ☐ YES ☐ NO

☐ Type A Infectious (Food) ☐ Type B Serum (Blood)
☐ Unknown (Explain)

9. Have you ever had liver disease or jaundice? (date) _____ ☐ YES ☐ NO

10. Do you have any blood disease? ☐ YES ☐ NO
☐ Anemia ☐ AIDS or positive test ☐ Leukemia
☐ Unknown (Explain) ☐ Other _____

11. Do you have any problems with excess bleeding? ☐ YES ☐ NO
If YES, please explain _____

12. Do you have stomach or intestinal ulcers? ☐ YES ☐ NO

13. Have you ever had tuberculosis? (date) _____ ☐ YES ☐ NO

14. Do you have emphysema, asthma or breathing problems? ☐ YES ☐ NO

15. Do you have any form of arthritis? ☐ YES ☐ NO
☐ Rheumatoid Arthritis ☐ Gout/Gouty Arthritis
☐ Osteoarthritis ☐ Other _____
Which joints are involved? _____

16. Have you ever had a hip or other joint replacement? ☐ YES ☐ NO

17. Have you ever had any injury, pain or soreness from your jaw joint? (TMJ dysfunction) ☐ YES ☐ NO

18. Have youe ver had any chronic head, neck or back pain problems? ☐ YES ☐ NO

19. Have you ever suffered trauma to your head or neck, such as in a car accident? ☐ YES ☐ NO
If YES, please describe _____

20. Do you have fainting spells, convulsions or epilepsy? ☐ YES ☐ NO

21. Have you had surgery, radiation or other treatment for a tumor or growth? ☐ YES ☐ NO
If YES, please describe _____

22. Do you have glaucoma? ☐ YES ☐ NO
☐ Right eye ☐ Left eye ☐ Both eyes

23. Is your diet medically prescribed? ☐ YES ☐ NO
If YES, please explain _____

24. Are you pregnant? (Expected delivery date) _____ ☐ YES ☐ NO

25. Do you have a history of previous miscarriages? ☐ YES ☐ NO

26. Have you reached menopause? ☐ YES ☐ NO
If YES, what hormones are you taking, if any? _____

27. Are you taking any calcium supplementation? ☐ YES ☐ NO