



Altus Research

4671 South Congress Avenue
Suite 100-B
Lake Worth, FL 33461

MEDICAL HISTORY

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Participant Name/Initials _____ Date _____

CONDITIONS: Check YES or NO column as applicable.

Condition	Yes	No	Description/Comment	Start Date	Ong	Res Date
EYES						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
EARS						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
NOSE or THROAT						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
CARDIOVASCULAR						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
LUNG / RESPIRATORY						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
ENDOCRINE						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
GASTROINTESTINAL						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
GENITOURINARY						

Participant Name/Initials _____ Date _____

Condition	Yes	No	Description/Comment	Start Date	Ong	Res Date
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
GYNECOLOGICAL						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
NEUROLOGICAL						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
MUSCULOSKELETAL						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
SKIN / INTEGUMENTARY						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
EMOTIONAL/ PSYCHOLOGICAL						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
IMMUNE SYSTEM						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
BLOOD DISORDER						
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
CANCER						

