

Constitution	
<input type="checkbox"/>	Negative
<input type="checkbox"/>	Chills
<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	Sleeping All the Time
<input type="checkbox"/>	Sudden Weight Loss
<input type="checkbox"/>	Sudden Weight Gain
<input type="checkbox"/>	Weakness

Cardiovascular	
<input type="checkbox"/>	Negative
<input type="checkbox"/>	Angina
<input type="checkbox"/>	Arrhythmia
<input type="checkbox"/>	Bypass Graft
<input type="checkbox"/>	Bypass Surgery
<input type="checkbox"/>	Chest Pain
<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	Coronary Artery Disease
<input type="checkbox"/>	Cyanosis
<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>	Heart Palpitation
<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	History of Heart Disease
<input type="checkbox"/>	High Blood Pressure Controlled
<input type="checkbox"/>	High Blood Pressure Uncontrolled
<input type="checkbox"/>	Irregular Heart Beat
<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Stent
<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Valve Replacement

Ear, Nose, Mouth, Throat	
<input type="checkbox"/>	Negative
<input type="checkbox"/>	Chronic Colds
<input type="checkbox"/>	Chronic Sinusitis
<input type="checkbox"/>	Chronic Strep Infections
<input type="checkbox"/>	Dentures
<input type="checkbox"/>	Ear Pain
<input type="checkbox"/>	Ear Infections
<input type="checkbox"/>	Ear Itching
<input type="checkbox"/>	Hearing Aid Right Ear
<input type="checkbox"/>	Hearing Aid Left Ear
<input type="checkbox"/>	Mouth Sores
<input type="checkbox"/>	Nose Bleeds
<input type="checkbox"/>	Partial Hearing Loss Right Ear
<input type="checkbox"/>	Partial Hearing Loss Left Ear
<input type="checkbox"/>	Otitis Media
<input type="checkbox"/>	Ringing in Ears
<input type="checkbox"/>	Runny Nose
<input type="checkbox"/>	Sinusitis
<input type="checkbox"/>	Sinus Pain
<input type="checkbox"/>	Sore Throat
<input type="checkbox"/>	Stuffy Nose

Respiratory	
<input type="checkbox"/>	Negative
<input type="checkbox"/>	Asthma
<input type="checkbox"/>	COPD
<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	Cough
<input type="checkbox"/>	Chronic Bronchitis
<input type="checkbox"/>	Chronic Cough
<input type="checkbox"/>	Collapsed Right Lung
<input type="checkbox"/>	Collapsed Left Lung
<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Lung Cancer
<input type="checkbox"/>	Pleurisy
<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Sarcoidosis
<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Tuberculosis

Gastrointestinal	
<input type="checkbox"/>	Negative
<input type="checkbox"/>	Abdominal Pain
<input type="checkbox"/>	Bowel Cancer
<input type="checkbox"/>	Change in Appetite
<input type="checkbox"/>	Crohn's Disease
<input type="checkbox"/>	Colitis
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	Diverticulitis
<input type="checkbox"/>	Esophagitis
<input type="checkbox"/>	Frequency of Bowel Movements
<input type="checkbox"/>	Gall Bladder Disease
<input type="checkbox"/>	Gastric Reflux
<input type="checkbox"/>	GERD
<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Hepatitis Type A
<input type="checkbox"/>	Hepatitis Type B
<input type="checkbox"/>	Hepatitis Type C
<input type="checkbox"/>	Hernia
<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	Nausea
<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	Stomach Cancer
<input type="checkbox"/>	Ulcers

Allergic/Immunologic	
<input type="checkbox"/>	Negative
<input type="checkbox"/>	Allergy Shots
<input type="checkbox"/>	HIV
<input type="checkbox"/>	Immune Disorder
<input type="checkbox"/>	Lupus
<input type="checkbox"/>	Seasonal Allergies

Gastroitourinary	
<input type="checkbox"/>	Negative
<input type="checkbox"/>	Bladder Infections
<input type="checkbox"/>	Bladder Repair
<input type="checkbox"/>	Bladder Spasms
<input type="checkbox"/>	Changes in Color of Urine
<input type="checkbox"/>	Dialysis
<input type="checkbox"/>	Endometriosis
<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	Incontinence
<input type="checkbox"/>	Kidney Failure
<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Kidney Transplant
<input type="checkbox"/>	Menopause Symptoms
<input type="checkbox"/>	Ovarian Cysts
<input type="checkbox"/>	Ovarian Cancer
<input type="checkbox"/>	Prostate Cancer
<input type="checkbox"/>	Recurrent Urinary Tract Infections
<input type="checkbox"/>	Renal Stricture
<input type="checkbox"/>	Renal Cancer
<input type="checkbox"/>	STD
<input type="checkbox"/>	Testicular Cancer
<input type="checkbox"/>	Uterine Fibroids
<input type="checkbox"/>	Uterine Cancer
<input type="checkbox"/>	Vulvular Cancer

Musculoskeletal	
<input type="checkbox"/>	Negative
<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Back Pain
<input type="checkbox"/>	Bone Cancer
<input type="checkbox"/>	Cerebral Palsy
<input type="checkbox"/>	Gout
<input type="checkbox"/>	Juvenile Rheumatoid Arthritis
<input type="checkbox"/>	Joint Pain
<input type="checkbox"/>	Limited Range of Motion
<input type="checkbox"/>	Muscle Pain
<input type="checkbox"/>	Polymyalgia
<input type="checkbox"/>	Rheumatoid Arthritis

Integumentary	
<input type="checkbox"/>	Negative
<input type="checkbox"/>	Basal Cell Carcinoma
<input type="checkbox"/>	Bruising
<input type="checkbox"/>	Changes in Color/Pigmentation
<input type="checkbox"/>	Changes in Hair/Nails
<input type="checkbox"/>	Dermatitis
<input type="checkbox"/>	Dryness
<input type="checkbox"/>	Eczema
<input type="checkbox"/>	Excessive Sweating
<input type="checkbox"/>	Itching
<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	Skin Cancer
<input type="checkbox"/>	Skin Rash

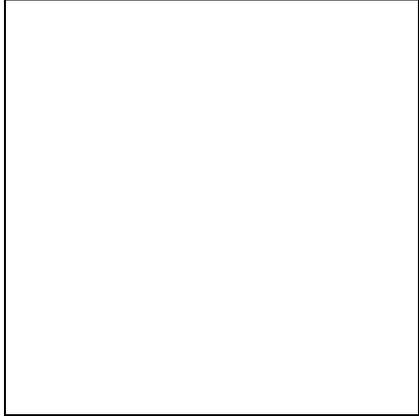
Neurological	
<input type="checkbox"/>	Negative
<input type="checkbox"/>	Bell's Palsy
<input type="checkbox"/>	Cranial Nerve Palsy
<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Involuntary Movement
<input type="checkbox"/>	Migraines
<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Stroke
<input type="checkbox"/>	TIA
<input type="checkbox"/>	Vertigo

Psychiatric	
<input type="checkbox"/>	Normal
<input type="checkbox"/>	Agitated
<input type="checkbox"/>	Confused
<input type="checkbox"/>	Depression
<input type="checkbox"/>	Dementia
<input type="checkbox"/>	Mood Swings
<input type="checkbox"/>	Nervousness
<input type="checkbox"/>	Oriented
<input type="checkbox"/>	Panic Episodes
<input type="checkbox"/>	Paranoia
<input type="checkbox"/>	Suicidal Thoughts
<input type="checkbox"/>	Violent

Endocrine	
<input type="checkbox"/>	Negative
<input type="checkbox"/>	Adrenal Gland Disorder
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	Hyperadrenal Gland
<input type="checkbox"/>	Hypoadrenal Gland
<input type="checkbox"/>	Hyperthyroidism
<input type="checkbox"/>	Hypothyroidism
<input type="checkbox"/>	Goiter

Hematologic/Lymphatic	
<input type="checkbox"/>	Negative
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Blood Disorders
<input type="checkbox"/>	Hemachromatosis
<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	Enlarged Lymph Nodes
<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	Lyme Disease
<input type="checkbox"/>	Lymphoma

Other	
<input type="checkbox"/>	Please Specify
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<input type="checkbox"/> Hemophilia
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