MEDICAL HISTORY

Today's Date:_____ Age: _____ Birthdate:_____

Name:_____ Sex: M ____ F ____

Address: _____ Home Phone: _____

_____ Work Phone: _____

_____ Cell Phone: _____

Occupation:_____ Emergency Contact: _____

E-Mail:_____ Phone #: _____

SIngle: _____ Married: _____ Divorced: _____ Widowed: _____ Separated: _____

MEDICAL HISTORY

Check (✓) when you had any of the following symptoms or diseases. Please check appropriate column indicating past ❍ or present ❑.

❍ ❑ Childhood Disease
❍ ❑ Ringing in Ear
❍ ❑ Ear Infections - *frequent*
❍ ❑ Dizzy Spells
❍ ❑ Fainting Spells
❍ ❑ Failing Vision ❍ ❑ Eye Pain
❍ ❑ Double or Blurred Vision
❍ ❑ Nose Bleeds - *recurrent*
❍ ❑ Sinus Trouble
❍ ❑ Sore Throats - *frequent*
❍ ❑ Hoarseness - *prolonged*
❍ ❑ Hayfever / Allergies
❍ ❑ Pneumonia / Pleurisy
❍ ❑ Bronchitis / Chronic Cough
❍ ❑ Asthma / Wheezing
❍ ❑ Shortness of Breath
❍ ❑ on exertion ❍ ❑ lying flat
❍ ❑ Chest Pain
❍ ❑ High Blood Pressure
❍ ❑ Heart Murmur
❍ ❑ Swollen Ankles
❍ ❑ Irregular Pulse ❍ ❑ Palpitations
❍ ❑ Leg Pain - *when walking*
❍ ❑ Varicose Veins / Phlebitis
❍ ❑ Cold Numb Feet
❍ ❑ Loss of Appetite - *recent*
❍ ❑ Difficulty Swallowing

❍ ❑ Heartburn ❍ ❑ Peptic Ulcer
❍ ❑ *Persistent* nausea / Vomiting
❍ ❑ Abdominal pain - *chronic*
❍ ❑ Gallbladder trouble
❍ ❑ Jaundice / Hepatitis
❍ ❑ Diarrhea ❍ ❑ Constipation
❍ ❑ Inflammatory Bowel Syndrome
❍ ❑ Bloody or tarry stools
❍ ❑ Hemorrhoids ❍ ❑ Hernia
❍ ❑ Urination - Overactive Bladder
❍ ❑ Overnight more than twice
❍ ❑ Increased Frequency
❍ ❑ Urgency to Urinate
❍ ❑ with leakage
❍ ❑ Decrease in force / flow
❍ ❑ painful
❍ ❑ Stress incontinence - urine leakage with exercise / movement
❍ ❑ Blood in Urine
❍ ❑ Kidney Stones
❍ ❑ Urine infections - *frequent*
❍ ❑ Sexually transmitted diseases
❍ ❑ Sexual Problems
❍ ❑ Multiple Sex Partners
❍ ❑ Weight Loss
❍ ❑ Weight Gain - *recent*
❍ ❑ Anemia
❍ ❑ Bruise Easily
❍ ❑ Blood Transfusions
❍ ❑ Cancer ❍ ❑ Chronic Fatigue

❍ ❑ Diabetes ❍ ❑ Thyroid Disease
❍ ❑ Seizures ❍ ❑ Stroke
❍ ❑ Tremor / Hands Shaking
❍ ❑ Numbness / TIngling Sensations
❍ ❑ Headaches - *frequent*
❍ ❑ Arthritis / Rheumatism
❍ ❑ Back Pain - *recurrent*
❍ ❑ Bone fracture / joint injury
❍ ❑ Osteoporosis
❍ ❑ Foot Pain ❍ ❑ Gout
❍ ❑ Rashes ❍ ❑ Hives
❍ ❑ Psoriasis ❍ ❑ Eczema
❍ ❑ Any type of sleeping difficulty
❍ ❑ Depression
❍ ❑ Nervousness
❍ ❑ Agitation ❍ ❑ Memory Loss
❍ ❑ Moodiness
❍ ❑ Suicidal Thoughts
❍ ❑ Phobias ❍ ❑ Mental Illness
❍ ❑ Feelings of worthlessness
❍ ❑ Rheumatic Fever
❍ ❑ Scarlet Fever
❍ ❑ Chicken Pox
❍ ❑ Polio
❍ ❑ Mumps ❍ ❑ Measles
❍ ❑ German Measles
❍ ❑ Tuberculosis ❍ ❑ Herpes

❍ ❑ AIDS / HIV
❍ ❑ Alcohol_____ oz. per week
❍ ❑ Coffee/Tea _____ cups per day
❍ ❑ Smoking: _____ cig / day
_____ # years
_____ year quit
❍ ❑ Exercise
❍ ❑ Street Drugs: _____
❍ ❑ Acupuncture / Tatoos
Hair Loss: ❍ ❑ Progressive
❍ ❑ Recent

MALES: ❍ ❑ Prostate problems

FEMALES: *Please Complete*
Menstrual Flow:
❍ ❑ Regular ❍ ❑ Irregular
❍ ❑ Pain / Cramps
Days of Flow: _____
Length of Cycle: _____
Date - 1st Day of last period _____
❍ ❑ Pain / Bleeding during or after sex

Number of:
Pregnancies _____
Abortions _____
Miscarriages _____
Live Births _____

Birth Control Method: _____
_____

B.C. pill (name): _____

❍ ❑ Flushing / Menopause

Date of Last Pap Test _____
❍ ❑ Normal ❍ ❑ Abnormal

Date of Last Mammogram_____
❍ ❑ Normal ❍ ❑ Abnormal

~ *Continued on Other Side* ~

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

Prescription	*Non-Prescription (Over the Counter)*	*Herbal/Non-Conventional*	VACCINE(S)	YEAR OF LAST
			Tetanus / Td	
			Influenza (flu)	
			Pneumonia	
			Hepatitis A	
			Hepatitis B	
			MMR	
			Chicken Pox	
			Polio	

ALLERGIES

FAMILY HISTORY

Follow the lines across and mark the appropriate cause of Death (age).

	Lives in good health	Deceased	Hypertension	Heart Failure	Epilepsy	Diabetes	Cancer	Asthma	Hay Fever	Arthritis	Kidney Failure	Glaucoma	Stroke	Migraine	Mental Health	Alcohol Abuse	Bleeding Disorder	Anemia	Psoriasis	Other
Father																				
Mother																				
Brother/Sister																				
Brother/Sister																				
Brother/Sister																				
Brother/Sister																				
Paternal Grandfather																				
Paternal Grandmother																				
Maternal Grandfather																				
Maternal Grandmother																				
Other Relatives																				

NOTES