

Family Medical History

Asthma Allergies Arthritis Addiction
 Cancer Diabetes Glaucoma Heart Disease
 Hypertension Hepatitis Mental disorders Stroke

Your Past Medical History

Asthma Allergies Arthritis Addiction
 Cancer Diabetes Glaucoma Heart Disease
 Hypertension Hepatitis HIV/AIDS Mental disorders
 Multiple Sclerosis Stroke TB Thyroid disorder

List any hospitalizations you have had during the past 5 (five) years:

Surgeries: _____

Do you have pacemaker? Yes No

Do you have any metal parts in your body? Yes No

If yes, where? _____

Are you getting any cancer treatment? Yes No

If yes, please specify _____

Physician _____ Phone _____

Are you taking any prescription pain medications? Yes No

If yes, for what reason? _____

Physician _____ Phone _____

Life Style:

How much per day/how often per week
Alcohol
Smoking
<input type="checkbox"/> Soda <input type="checkbox"/> Diet Soda
<input type="checkbox"/> Coffee/Tea <input type="checkbox"/> Decaf Coffee/Te
Plain Water
Eat Out (Fast Food/Resturant)
Fruits
Vegetable
Meat <input type="checkbox"/> Pork <input type="checkbox"/> Beef <input type="checkbox"/> Chicken <input type="checkbox"/> Lamb <input type="checkbox"/> Fish <input type="checkbox"/> Sea Food
Milk/Soy milk <input type="checkbox"/> Skim <input type="checkbox"/> 1% <input type="checkbox"/> 2% <input type="checkbox"/> Whole
Exercise, what type and how often?

General Symptoms

Fever Chills
 Strongly like cold drinks Strongly like hot drinks

Allergies _____

Pain

Yes No If yes, where? _____

Energy Level

low high fatigue shortness of breath sweat easily body feels heavy

Appetite

poor excess cravings, for what? _____

Sleep

too little too much nightmare nightsweats

Circulation

poor cold feet cold hands cold body cold head bruise or bleed easily

Urination

frequent difficult painful bed wetting

Bowel Movement

constipation diarrhea irritable bowel syndrome

Stress

high, reasons _____
 low

Sexual activity

Yes No low libido high libido sexual transmitted disease

Head, Eye, Ear, Nose, Mouth, Throat

<input type="checkbox"/> Headaches	<input type="checkbox"/> Prescription Glasses	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Ringing in Ear	<input type="checkbox"/> Ear Aches
<input type="checkbox"/> Poor Hearing	<input type="checkbox"/> Nose Bleed	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Gum problems	<input type="checkbox"/> TMJ	<input type="checkbox"/> Teeth Problems

Respiratory

Difficult Breathing Shortness of Breath Asthma/Wheezing Cough

Cardiovascular

High Blood Pressure Low Blood Pressure Palpitations Taking Blood Thinner

Gastrointestinal

Nausea Vomiting Acid Regurgitation Hiccups
 Bloating Hemorrhoids Bloody Stools Black Stools

Musculoskeletal

Pain in: Neck Shoulder Elbow Wrist Hands/Arm Hip
 Knee Ankle Foot/Leg Sciatica Upper back Rib
 Lower Back

Muscles Pain Weakness Spasm Atrophy Paralysis
 Osteoporosis Rheumatoid Arthritis Osteoarthritis
 Degenerative Disk Herniated Disk Scoliosis
 Numbness, where _____

Skin and Hair

Rashes Hives Itching Ulcerations Acne
 Eczema Psoriasis Hair Loss Shingles
 Skin Cancer, Treatment _____
Physician _____ Phone _____

Neuropsychological

Seizures Irritability Depression Anxiety Considered or Attempted Suicide

Men Only

Annual Prostate Exam Prostate Enlargement
 Prostate Cancer, Treatment _____
Physician _____ Phone _____
 Incontinence Impotence Premature ejaculation

Women Only

Age of first Period _____ Duration of Period _____ days, Length of cycle _____ days
 Irregular Periods Painful Period Blood Clots PMS
 Heavy Vaginal Discharge, color _____

Age of Menopause _____ Hot Flushes? _____
Are you under a Gynecologist's Care? _____
Physician _____ Phone _____

Breast Self Exam Breast Lumps Breast pain
 Breast Cancer, Treatment _____
Physician _____ Phone _____
 Birth Control, what method? _____

Date last period began _____
Are you pregnant? Yes No, if yes, how many weeks? _____
Physician _____ Phone _____

Number of Pregnancies _____ Number of Miscarriages _____ Number of Live Births _____

