Medical History

Today's Date _____

Patient Name_____ Date of Birth _____

Your Height: _____ Your Weight: _____

Main Problems (Chief Complaint):

List the main problems that you wish to address - current medical problems/date started

_____

_____

_____

_____

_____

YOUR SYMPTOMS (History of Main Problems):

Please list any symptoms that you have now or experienced: (Please check past or present and how severe and frequent the problem)

		Past	Present	How severe	How Frequent
1.	Headaches	☐	☐		
2.	Problems with vision, hearing, taste or smell	☐	☐		
3.	Chest Pain or shortness of breath	☐	☐		
4.	Cough, wheezing or other difficulties	☐	☐		
5.	Heartburn, gas, bloating, indigestion	☐	☐		
6.	Constipation, diarrhea, hemorrhoids	☐	☐		
7.	Urinary tract problems, stones, infections in the bladder or kidney	☐	☐		
8.	Gynecologic problems(specify)	☐	☐		
9.	Infertility, impotence, low libido	☐	☐		
10.	Skin or hair problems	☐	☐		
11.	Bone or joint disorders	☐	☐		
12.	Neurological problems, Fasciculations	☐	☐		
13.	Mood, emotion, or psychiatric problems	☐	☐		
14.	Fatigue, night sweats, loss of motivation	☐	☐		

Allergies or adverse drug reactions: (List Known Allergies to medication and type of reactions)

_____

_____

Other Allergies: Check all that apply:

☐ Dairy ☐ Wheat ☐ Corn ☐ Eggs ☐ Peanuts ☐ shellfish ☐ Chemicals ☐ DON'T KNOW

Do you react to pollen? ☐ Yes ☐ No Reaction _____

Do you react to molds? ☐ Yes ☐ No Reaction _____

Do you react to foods? ☐ Yes ☐ No Reaction _____

MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications such as aspirin, ibuprofen, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

NUTRITIONAL & HERBAL PREPARATIONS

Preparation	Dose	How often taken

Habits: Do you smoke? No_____ Yes_____

If yes, how many packs per day?_____

If you have quit, how long ago? _____

Do you use alcohol? No_____ Yes_____

If yes, how often do you drink?_____

Do family or friends worry about your alcohol intake? _____

Have you ever had problems with drug use?_____

Have you ever had a COVID Vaccine? No_ Yes_ When? _____ How many booster shots?___

Please indicate past or present amounts:

	Daily	Weekly	Occasionally	Never	Past
Coffee/caffeine					
Aspirin					
Laxatives					
Exercise					
Meditation					

ILLNESSES & DISEASES (Past Medical History):

Date of last complete checkup _____ Results _____

Names of recent Doctors consulted _____

PAST MEDICAL HISTORY:

Please list all Accidents and Injuries:

Please list other diseases from which you currently suffer (heart, lung, etc.):

Please list any surgeries (operations), reason for the surgery, and date of surgery:

FAMILY HISTORY: Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	grandparents	father	mother	brother	sister	son	daughter	other
Allergies								
Asthma								
Cancer (specify)								
Heart disease								
Stroke								
Lung disease (specify)								
Diabetes								
High blood pressure								
Liver disease								
High cholesterol								
Alcohol/drug abuse								
Neurologic disease (specify)								
Depression/psychiatric illness								
Genetic (inherited) disorder								
Other								

REVIEW OF SYSTEMS:

SYMPTOM REVIEW

Gastrointestinal
- ☐ poor appetite
- ☐ abdominal pain
- ☐ indigestion
- ☐ trouble swallowing
- ☐ diarrhea
- ☐ constipation
- ☐ change in bowel habits
- ☐ nausea or vomiting
- ☐ rectal bleeding or blood in stools
- ☐ history of liver disease or abnormal liver tests

Cardiovascular
- ☐ chest pain
- ☐ history of angina or heart attack
- ☐ history of high blood pressure
- ☐ history of irregular beat
- ☐ history of poor circulation

Pulmonary/lungs
- ☐ shortness of breath
- ☐ persistent cough
- ☐ coughing up blood
- ☐ asthma or wheezing

Muscle/joint/bone
- ☐ swelling of ankles or legs
- ☐ pain, weakness or numbness in
- ☐ arms or hands
- ☐ back or hips
- ☐ legs or feet
- ☐ neck or shoulders

Neurologic
- ☐ history of stroke
- ☐ blackouts or loss of consciousness

General
- ☐ weight gain/loss of 10+ lbs during last 6 months
- ☐ poor sleep
- ☐ fever
- ☐ headache
- ☐ depression

Eyes, ears, nose, throat
- ☐ blurred vision
- ☐ other change in vision
- ☐ history of glaucoma or cataracts
- ☐ loss of hearing
- ☐ ringing in ears
- ☐ sinus problems
- ☐ hoarseness

Genitourinary
- ☐ frequent or painful urination
- ☐ blood in urine

Skin
- ☐ itching
- ☐ easy bruising
- ☐ change in moles

Endocrine
- ☐ history of diabetes
- ☐ history of thyroid disease
- ☐ change in tolerance to hot or cold weather
- ☐ excessive thirst

Women only
- ☐ abnormal Pap smear
- ☐ bleeding between periods
- date of last mammogram_____

Men only
- ☐ Elevated PSA

Anything else?
- ☐ Are you experiencing an unusually stressful situation?
- ☐ Are there any specific personal issues you would like to bring up at the time of your visit?

WORK HISTORY

Current Occupation: _____ How Long? _____

Past Occupations: _____ How long? _____

_____ How long? _____

****

Thank you for taking the time to carefully complete this form.
It is the beginning of your process of healing and good health!