Past Medical History

Check any of the following conditions you currently have or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

- ☐ AIDS/ HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Birth Trauma (your own birth)
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other (specify): _____

List medications you are currently taking.

Medications	Strength	How many per day?	For how long?

List substances or medications you are allergic to.

_____

List any major surgeries you have had.

Date	Problem

List significant trauma (Auto accident, falls).

_____

_____

_____

List significant family history.

_____

_____

_____

Your Diet

Appetite ☐ High ☐ Low

- ☐ Coffee
- ☐ Soft Drinks
- ☐ Artificial Sweetener
- ☐ Sugar
- ☐ Salty Food

Thirst for Water:
# of Glasses per Day: _____

Vitamins taken in the past two months: _____

Your Lifestyle

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ Drugs
- ☐ Stress
- ☐ Occupational Hazards
- ☐ Regular Exercise
  Type: _____ Frequency: _____
  Type: _____ Frequency: _____

General Symptoms

- ☐ Poor Appetite
- ☐ Heavy Appetite
- ☐ Strongly like Cold Drinks
- ☐ Strongly like Hot Drinks
- ☐ Recent Weight Loss
- ☐ Recent Weight Gain
- ☐ Poor Sleep
- ☐ Heavy Sleep
- ☐ Dream-disturbed Sleep
- ☐ Fatigue
- ☐ Lack of Strength
- ☐ Bodily Heaviness
- ☐ Cold Hands or Feet
- ☐ Poor Circulation
- ☐ Shortness of Breath
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Sweats Easily
- ☐ Muscle Cramps
- ☐ Vertigo or Dizziness
- ☐ Bleed or Bruise Easily
- ☐ Peculiar Taste (describe): _____

Head, Eyes, Ears, Nose, and Throat

- ☐ Glasses
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Red Eyes
- ☐ Itchy Eyes
- ☐ Spots in Eyes
- ☐ Poor Vision
- ☐ Blurred Vision
- ☐ Night Blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Teeth Problems
- ☐ Grind Teeth
- ☐ TMJ
- ☐ Facial Pain
- ☐ Gum Problems
- ☐ Sores on Lips or Tongue
- ☐ Dry Mouth
- ☐ Excessive Saliva
- ☐ Sinus Problems
- ☐ Excessive Phlegm
- ☐ Color of Phlegm: _____
- ☐ Recurrent Sore Throat
- ☐ Swollen Glands
- ☐ Lumps in Throat
- ☐ Enlarged Thyroid
- ☐ Nose Bleeds
- ☐ Ringing in Ears
- ☐ Poor Hearing
- ☐ Earaches
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions
- ☐ Other Head/Neck Problems: _____

Respiratory

- ☐ Pneumonia
- ☐ Difficulty Breathing when lying down
- ☐ Shortness of Breath
- ☐ Tight Chest
- ☐ Asthma/ Wheezing
- ☐ Cough
  Wet or Dry? _____
  Thick or Thin? _____
- Color of Phlegm: _____
- ☐ Coughing Blood

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Blood Clots
- ☐ Fainting
- ☐ Chest Pain
- ☐ Difficulty Breathing
- ☐ Tachycardia
- ☐ Heart Palpitations
- ☐ Phlebitis
- ☐ Irregular Heartbeat

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Acid Regurgitation
- ☐ Gas
- ☐ Hiccups
- ☐ Bloating
- ☐ Bad Breath
- ☐ Diarrhea
- ☐ Constipation
- ☐ Laxative Use
- ☐ Black Stools
- ☐ Mucous in Stools
- ☐ Intestinal Pain or Cramping
- ☐ Itchy Anus
- ☐ Burning Anus
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Anal Fissures

Bowel Movements:
Frequency: _____
Color: _____
Odor: _____
Texture/ Form: _____
_____

Musculoskeletal

- ☐ Neck/ Shoulder Pain
- ☐ Muscle Pain
- ☐ Upper Back Pain
- ☐ Lower Back Pain
- ☐ Joint Pain
- ☐ Rib Pain
- ☐ Limited Range of Motion
- ☐ Limited Use
- ☐ Other (describe): _____

Skin and Hair

- ☐ Rashes
- ☐ Hives
- ☐ Ulceration
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Dandruff
- ☐ Itching
- ☐ Hair Loss
- ☐ Change in Hair/ Skin Texture
- ☐ Fungal Infection
- ☐ Other Hair/Skin Problems: _____

Neuropsychological

- ☐ Seizures
- ☐ Numbness
- ☐ Tics
- ☐ Poor Memory
- ☐ Depression
- ☐ Anxiety
- ☐ Irritability
- ☐ Easily Stressed
- ☐ Abuse Survivor
- ☐ Considered/ Attempted Suicide
- ☐ Seeing a Therapist
- ☐ Other (specify): _____

Genitourinary

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Urgent Urination
- ☐ Blood in Urine
- ☐ Incontinent
- ☐ Incomplete Urination
- ☐ Venereal Disease
- ☐ Bedwetting
- ☐ Wake to Urinate
- ☐ Increased Libido
- ☐ Decreased Libido
- ☐ Kidney Stones
- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Nocturnal Emission
- ☐ Other: _____

Gynecological

Age Menses Began: _____
Length of Cycle (Day 1 to Day 1)
☐ Clots
Age at Menopause: _____
☐ Irregular Periods
☐ Painful Period
# of Premature Births: _____
Date Last Period Began: _____
Date of Last PAP:
# of Live Births: _____
Duration of Flow: _____
☐ Vaginal Discharge
Color: _____
# of Pregnancies: _____
☐ Vaginal Odor
☐ Vaginal Sores ☐ PMS
☐ Breast Lumps