

## MEDICAL HISTORY (1)

(PAGE 1 OF 4) PLEASE COMPLETE ALL 4 PAGES.

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M/F

Marital Status (circle one):    single            married            life partner            divorced            widowed

Do you have children? If yes, please list names and ages: \_\_\_\_\_  
\_\_\_\_\_

*If you need additional space for any of the following questions, please attach an extra page.*

### PRESENT HEALTH CONCERNS:

What are your most important health concerns listed in order of importance?

Describe in detail the history of these symptoms and the effect they have on your life.

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

### MEDICINES:

Please list all of the **prescription** and **over-the-counter medications** you are currently taking *including dosage and frequency*.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### SUPPLEMENTS:

Please list all of the **nutritional** and **herbal supplements** you are taking including *brand name, dosage and frequency*.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### ALLERGIES:

Please list all known **allergies** (drug, food, chemical and environmental):

\_\_\_\_\_  
\_\_\_\_\_

### MEDICAL HISTORY:

Please list all hospitalizations and treatments you have used for various ailments, both conventional and alternative.

Indicate the effectiveness of each treatment. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### SURGICAL HISTORY:

Please list any **surgeries** and dates: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

### ACCIDENTS:

Please describe all serious **accidents**, severe injuries, head injuries and broken bones and dates: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

# MEDICAL HISTORY (2)

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On the picture, mark and "X" on the picture where you continue to have pain, numbness and/or tingling.

Please rate the severity of pain on a scale of 1-10 (1=least pain): \_\_\_\_\_

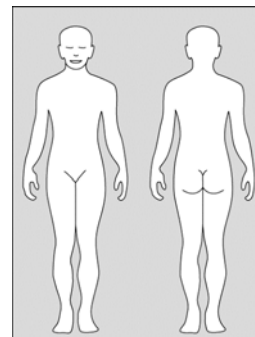
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching

Shooting  Burning  Tingling  Cramps  Stiffness  Swelling  Other

How often do you have this pain? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

Activities that are painful: Sitting Standing Walking Bending Lying down



## Have you ever had the following (circle "Y" for yes and "N" for no)?

Alcoholism	Y	N	Anemia	Y	N	Anorexia/Bulimia	Y	N
Arthritis	Y	N	Asthma	Y	N	Back Trouble	Y	N
Bleeding/Bruising	Y	N	Blood Transfusion	Y	N	Breast Lump	Y	N
Bronchitis (chronic)	Y	N	Cancer	Y	N	Cataracts	Y	N
Diabetes	Y	N	Drug Dependency	Y	N	Emphysema	Y	N
Epilepsy	Y	N	Glaucoma	Y	N	Gout	Y	N
Heart Disease	Y	N	Hemorrhoids	Y	N	Hernia	Y	N
High Blood Pressure	Y	N	High Cholesterol	Y	N	Hives/Eczema	Y	N
Kidney Disease	Y	N	Liver Disease	Y	N	Low Blood Pressure	Y	N
Migraines	Y	N	Mitral Valve Prolapse	Y	N	Multiple Sclerosis	Y	N
Pacemaker	Y	N	Prostate Problems	Y	N	Psychiatric Care	Y	N
Stroke	Y	N	Thyroid Disease	Y	N	Ulcers	Y	N
Varicose Veins	Y	N	Other _____					

## Have you ever had any of the following infections (please circle any infection you have ever had)?

AIDS/HIV	Bladder Infections	Bronchitis	Chicken Pox	Diphtheria
Hepatitis	Herpes	Measles	Mono	Mumps
Pneumonia	Polio	Rheumatic Fever	Rubella	Scarlet Fever
Sexually Transmitted	Shingles	Sinusitis	Tonsillitis	Tuberculosis
Typhoid Fever	Vaginal Infections	Whooping Cough		

## FOR WOMEN

Age at 1<sup>st</sup> period: \_\_\_\_\_

Period frequency (i.e. 28 days) \_\_\_\_\_

Days of flow? \_\_\_\_\_

Any problems with PMS? \_\_\_\_\_

Any irregularities with periods? \_\_\_\_\_

Last menstrual period? \_\_\_\_\_

Extreme menstrual pain? \_\_\_\_\_

Are you satisfied with sex life? \_\_\_\_\_

Any history of infertility? \_\_\_\_\_

Last Pap: \_\_\_\_\_

Ever have an abnormal Pap? Yes No

If "yes" describe: \_\_\_\_\_

Do you do self breast exam? Yes No

Last mammogram? \_\_\_\_\_

History of breast lump? Yes No

If "yes", describe: \_\_\_\_\_

Any hot flashes or night sweats? Yes No

List each pregnancy including abortions, miscarriages and births (including *birth date*). If complications with pregnancy or delivery (including C-section), please describe: \_\_\_\_\_

# MEDICAL HISTORY (3)

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## FOR MEN

Last prostate exam? \_\_\_\_\_ Last PSA? \_\_\_\_\_  
How many times do you get up at night to urinate? \_\_\_\_\_  
Are you satisfied with your erections? Y N Are you satisfied with your sex life? Y N

## MEDICAL SERVICES

Please indicate the date you last received the following or put N/A for services that do not apply to you:

Tetanus shot _____	Flu shot _____	Pneumonia shot _____
Blood tests _____	EKG _____	Chest X-Ray _____
Colonoscopy _____	Eye Exam _____	Dental Exam _____
Bone Density _____	Coronary calcium score _____	

## LIFESTYLE

List other physicians/healers you are seeing (name/phone): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## DIET

Do you have any dietary restrictions? \_\_\_\_\_  
Do you have any cravings for any particular type of food (be specific)? \_\_\_\_\_

Are you satisfied with your diet? Yes No  
If "no" to the above, why? \_\_\_\_\_  
How much water do you drink daily? \_\_\_\_\_ Other liquids? \_\_\_\_\_

What did you eat and drink yesterday or a typical day (please be specific)?

Breakfast: \_\_\_\_\_  
Snack: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Snack: \_\_\_\_\_  
Dinner: \_\_\_\_\_  
Snack: \_\_\_\_\_

Smoking (type and amount per day) \_\_\_\_\_  
If you are a former smoker, what was your quit date? \_\_\_\_\_  
Do you drink alcohol? (type and amount per week) \_\_\_\_\_  
If you used to drink alcohol, when did you quit? \_\_\_\_\_  
Do you drink caffeine? (type and amount per week) \_\_\_\_\_  
Do you use recreational drugs? (type and amount per week) \_\_\_\_\_  
Usual weight? \_\_\_\_\_ Are you happy with your weight? \_\_\_\_\_  
How much sleep do you get? \_\_\_\_\_ Do you feel rested enough? \_\_\_\_\_

## EXERCISE:

Please describe the exercise you do each week (include minutes per session and days per week):  
\_\_\_\_\_  
\_\_\_\_\_

Do you enjoy exercise? Yes No

# MEDICAL HISTORY (4)

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## STRESS LEVEL AND STRESS REDUCTION

Describe your stress level (circle one): none mild moderate severe

Describe any stress reduction you practice including minutes per session and frequency: \_\_\_\_\_

Do you enjoy your work/what you do during the day? \_\_\_\_\_

Do you enjoy the people/pets in your life? \_\_\_\_\_

Do you live near an agricultural/industrial area? \_\_\_\_\_

Do you use paint, chemicals or solvents at home, for hobbies, or during work? \_\_\_\_\_

Have you moved to a new home recently? \_\_\_\_\_

Have you done any remodeling recently? \_\_\_\_\_

Do you have any mold in your home or work area? \_\_\_\_\_

Do you suffer from allergies? \_\_\_\_\_

How many times have you used antibiotics in the past two years? \_\_\_\_\_

List dental history (procedures): \_\_\_\_\_

List any cosmetic surgery or procedures: \_\_\_\_\_

List travel history and vaccinations: \_\_\_\_\_

## FAMILY HISTORY

(please include any family member who has had the following illnesses):

	Relationship			Relationship	
Allergies/Asthma	N	Y	_____	Anemia	N Y _____
Arthritis	N	Y	_____	Bleeding	N Y _____
Cancer	N	Y	_____	Depression	N Y _____
Diabetes	N	Y	_____	Drugs/Alcohol	N Y _____
Gout	N	Y	_____	Heart Disease	N Y _____
High Blood Press.	N	Y	_____	High Cholesterol	N Y _____
Kidney Disease	N	Y	_____	Mental Illness	N Y _____
Migraines	N	Y	_____	Obesity	N Y _____
Stroke	N	Y	_____	Thyroid Disease	N Y _____
Other:	_____				

If living, current health (good, fair, poor)

If Deceased, Cause of Death

	Present Age	Age at Death	
Paternal Grandmother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____