Fox Valley Wellness Center/Midwest Hyperbarics

MEDICAL HISTORY FORM

NAME _____ AGE _____ TODAY'S DATE _____

1. MEDICAL HISTORY

A. **List past or present illnesses, injuries, surgeries, hospitalizations:**

TYPE	DATES	TREATMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____

B. **Any physical limitations?**

_____

C. **List any prescription or OTC medications, vitamins, minerals, or supplements on a daily basis**

_____ _____

_____ _____

D. **List allergies (ex-hay fever, bee sting, foods, medications, molds, dust, animals, latex, etc.)**

_____ _____

_____ _____

E. **Family History**

History of premature sudden death, heart attack, stroke, diabetes, cancer, hypertension or asthma?

_____ _____

_____ _____

F. **Have you had any metal devices placed in your body? i.e. dental amalgams or restorations, prosthetic joints, IUD's, vascular stents or have you reacted to any metal- jewelry, buttons, cosmetics**

YES NO DESCRIBE _____

G. **Habits**

	YES	NO	AMOUNT
Cigarettes	____	____	_____
Alcohol	____	____	_____
Caffeine	____	____	_____

H. **Social History**

Marital Status _____ Children _____

Occupation _____ Frequent travel ____

I. **Do you now have, or have you sought medical care for any of the following?**

MENTAL HEALTH	NO	YES	DESCRIBE
Depression	___	____	_____
Insomnia	___	____	_____
Fatigability	___	____	_____
Eating Disorders	___	____	_____
Other	___	____	_____
HEAD AND NECK	**NO**	**YES**	**DESCRIBE**
Frequent headaches	___	____	_____
Chronic Sinus	___	____	_____
Glasses/Contacts	___	____	_____
Hearing Difficulty	___	____	_____
Sores of the mouth	___	____	_____
Root Canal	___	____	_____
Other _____	___	____	_____

LUNGS/BREATHING	NO	YES	DESCRIBE
Wheezing	___	____	_____
Shortness of breath	___	____	_____
Chronic Cough	___	____	_____
Asthma	___	____	_____
HEART AND CIRCULATION			
Chest pains	___	____	_____
Irregular heart beats	___	____	_____
Leg/feet swelling	___	____	_____
High blood pressure	___	____	_____
Exertional	___	____	_____
Heart murmur	___	____	_____
DIGESTIVE			
Recent weight changes	___	____	_____
Diarrhea/Constipation	___	____	_____
Nausea/Vomiting	___	____	_____
Jaundice (yellow skin or eyes)	___	____	_____
KIDNEY/BLADDER REPRODUCTIVE			
Abnormally colored urine	___	____	_____
Kidney disease	___	____	_____
Frequent urine infections	___	____	_____
Severe menstrual cramps	___	____	_____
CANCER			
Precancerous condition	___	____	_____
Cancer	___	____	_____
HEMATOLOGICAL			
Blood Transfusions	___	____	_____
HIV, Hepatitis	___	____	_____
BONE/JOINT/MUSCLE			
Hernia	___	____	_____
Carpal Tunnel Syndrome	___	____	_____
Joint pain/arthritis	___	____	_____
Strain/sprain	___	____	_____
SKIN			
Rashes	___	____	_____
Other skin problems	___	____	_____
NEUROLOGIC			
Seizures	___	____	_____
Tremors	___	____	_____
Loss of consciousness	___	____	_____
ENDOCRINE			
Diabetes	___	____	_____
Thyroid problems	___	____	_____
Unexplained weight changes	___	____	_____
Other glandular problems	___	____	_____

PATIENT SIGNATURE _____ **DATE** _____