

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

	<u>YES</u>	<u>NO</u>	<u>AMOUNT</u>
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?

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

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

PATIENT SIGNATURE _____ DATE _____