



MEDICAL HISTORY

Please take the time to fill in all the blank spaces.

Date _____ Referred by _____ Primary Physician _____
Name (First, Middle, Last): _____ Age _____

Reason for appointment (Please specify diagnosis or region of the body): _____

PAST MEDICAL HISTORY

Allergies: _____ Latex Allergy: Yes No Reaction _____

Current Medications: _____

Surgical History: (operations, dates, complications): _____

Medical Problems/Hospitalizations: _____

Special Diet: Yes No _____ Regular Exercise: Yes No (x/week) _____

Sports Activities: _____

FAMILY/SOCIAL HISTORY

Family Medical History (Heart Disease, Arthritis, Cancer, Diabetes, Hypertension etc.)

Marital Status: _____ Level of Education: _____ Special Needs Yes No

Occupation: _____ Employer _____ Last Day of Work _____

Tobacco: Yes No Packs Per Day: _____ If you have stopped, how long ago? _____

Alcohol: Yes No Drinks Per Week _____ Coffee: Yes No No Cups Per Day: _____

Drug Use Yes No Drugs Used and When _____

COMPLETE REVIEW OF MEDICAL HISTORY

For each of the following Categories, please **CIRCLE** any symptoms or conditions you have now or have had recently. Please place a **CHECK** by any symptoms or conditions you are currently experiencing:

CONSTITUTIONAL

Unexplained weight loss
Loss of energy
Loss of appetite
Fever or chills
History of cancer (type)

Other _____

EYES/EARS/NOSE/THROAT

Loss or change of vision
Eye pain or redness
Glaucoma
Cataracts
Double or blurred vision
Loss of Hearing
Buzzing or noise in the ear
Ear infection or drainage
Hoarseness
Congestion
Nose bleeds
Difficulty swallowing
Other _____

CARDIOVASCULAR

High blood pressure
Heart attack
Heart murmur
Chest pain
Abnormal heartbeat
Rheumatic fever
Calf "cramps" with walking
Sensitivity of fingers/toes to cold
Varicose veins
Swollen ankles and feet
Poor circulation
Other _____

RESPIRATORY

Asthma
Emphysema
Sleep apnea
Severe snoring
Wheezing
Chronic cough
Large quantity of sputum
Night sweats
Pneumonia
Tuberculosis
Other _____

GASTROINTESTINAL

Heartburn or reflux
Gallbladder disease
Recurring diarrhea
Frequent constipation
Loss of bowel control
Hernia
Digestive difficulties
Frequent nausea or vomiting
Frequent abdominal pain
Bloody vomit
Loss of appetite
Recurring diarrhea
Bloody stools
Hemorrhoids
Hepatitis
Other _____

GENITOURINARY

Urinary incontinence or dribbling
Bloody urine
Increased frequency of urination
Decreased stream
Difficulty urinating
Kidney stones

FEMALE ONLY

Painful menses or excess bleeding
Pregnancy or possibility
Uterine fibroids or tumors
Breast pain
Difficulty in sexual functioning

MALES ONLY

Penile pain
Abnormality of testicles
Scrotal swelling
Varicocele
Difficulty with sexual functioning
Other _____

SKIN

Chronic rash
Psoriasis
Poor wound healing
History of skin ulcers
Chronic fungal infections
Other _____

ENDOCRINE

Diabetes mellitus
Thyroid disorder
Osteoporosis

Hormone imbalance

Other _____

HEMATOLOGIC/LYMPH

Blood disorder
Anemia or low blood count
Blood clot/DVT/PE
Easy bruising
Excessive bleeding
Swollen lymph glands
Other _____

ALLERGY/IMMUNE

Hay fever or allergies
Food allergies
Immune disorder
Recurring infections
HIV
Other _____

PSYCHOLOGICAL

Depression
Excessive worry or anxiety
Severe tension
History of abuse
Feeling of hopelessness/worthlessness
Difficulty sleeping
Emotional problems
Other _____

NEUROLOGICAL

Stroke
Seizures or convulsions
Shaking or twitching spells
Frequent or severe headaches
Dizziness
Paralysis
Other _____

MUSCULOSKELETAL

Gout
Arthritis
Neck pain
Back pain
Sciatica
Spine abnormality
Tendonitis
Bursitis
History of polio
Torn ligaments/muscles/tendons
Numbness or tingling
Other _____

Signature: _____

Name of person completing this form if other than patient: _____

Relationship to patient: _____