

MEDICAL HISTORY FORM

INSTRUCTIONS – This medical questionnaire will assist us in understanding your medical status. It should take about 15-20 minutes to complete. Please answer all questions fully, printing or writing legibly (not like a doctor!). If you are uncertain about a question or answer, use a question mark (?). Use a separate sheet of paper if some of your answers require extra space. Thank you for helping us help you.

Name _____ Date of Birth _____ Age _____ SS# _____
Home Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____ E-Mail _____
Referring M.D. _____ Primary Care Doctor _____ Today's Date _____

SOCIAL HISTORY:

Present Marital Status: Single/Separated/Divorced/Married/Widowed

Tobacco: Give type, average daily use and duration of use. If a former tobacco user, give same information and when you stopped.

Employment: List employer and present position.

Caffeine: Give daily use of caffeine – Coffee/Tea/Cola/Chocolate

Stress Issues:

Recreational Drug Use: Give type (Cocaine, Heroin, Marijuana, etc.) or prescription drug misuse. Any substance abuse treatment?

NON-TRADITIONAL MEDICATIONS/THERAPIES: List current herbs, dietary supplements or alternative therapies.

FAMILY HISTORY: Please provide the following information about your parents, siblings and children.

| | Age if Living | Health (List significant illnesses.) | Age at Death | If Deceased, Cause |
|-----------|---------------|--------------------------------------|--------------|--------------------|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| Sisters | | | | |
| Sons | | | | |
| Daughters | | | | |

Check (✓) if your parents, brothers, sisters, grandparents, aunts, uncles or children have had any of the following conditions.

- | | | |
|--|---|---|
| <input type="checkbox"/> Liver Disease/Cirrhosis | <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Ulcerative Colitis |
| <input type="checkbox"/> Esophageal Cancer | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Stomach Cancer | <input type="checkbox"/> Celiac Disease/Sprue | <input type="checkbox"/> None |

REVIEW OF SYSTEMS: Check (✓) if you have had any of the following symptoms or disorders.

CONSTITUTIONAL:

- Good Health Lately
- Unusual Fatigue/Weakness

EYES:

- Glaucoma
- Wear Glasses/Contact Lenses

ENT:

- Deafness
- Ringing In Ears
- Chronic Sinus Problems/Runny Nose
- Sore Throat/Hoarseness/Voice Change
- Sore/Burning Tongue

CARDIOVASCULAR:

- Chest Pain/Angina Pectoris
- Palpitations
- Heart Murmur
- High Blood Pressure
- Mitral Valve Prolapse
- Heart Attack
- Congestive Heart Failure
- High Cholesterol/Triglycerides

RESPIRATORY:

- Chronic or Frequent Cough
- Coughing or Spitting Up Blood
- Shortness of Breath
- Asthma/Recurrent Wheezing
- Emphysema

GASTROINTESTINAL:

- Nausea
- Vomiting
- Heartburn
- Indigestion/Dyspepsia
- Stomach Fluid Refluxing Into The Mouth
- Peptic Ulcers
- Trouble or Pain With Swallowing
- Lump or Sensation In Throat
- Food Sticking
- Upper Abdominal Pain
- Bloating
- Belching
- Lower Abdominal Pain
- Frequent Diarrhea
- Frequent Constipation
- Rectal Bleeding
- Black or Tarry Stools
- Hidden Blood in Stool
- Excessive Rectal Gas/Flatus
- Loss of Stool/Fecal Accident
- Anemia
- Chronic Aspirin Use
- Poor Appetite
- Weight Loss
- Pancrease Problems
- Hepatitis in the Past
- Transfusion
- Herb Use
- Abnormal Liver Blood Tests

GENITOURINARY:

- Burning Or Pain On Urination
- Blood In Urine
- Hesitancy, Dribbling Or Poor Stream When Urinating
- Kidney Disease/Stones
- Kidney Failure
- Sexually Transmitted Disease
- Men: Prostate Problem
- Women: Menstrual Irregularity Or Abnormal Bleeding
- Pelvic Pain
- Pregnant Or Planning Pregnancy
- Pain On Intercourse

MUSCULOSKELETAL:

- Joint Pain(S)/Arthritis
- Weakness Of Muscles Or Joints
- Back Pain
- Gout
- Fibromyalgia

INTEGUMENTARY (SKIN/BREAST):

- Rashes Or Itching
- Change In Skin Color Or Moles
- Varicose Veins
- Breast Pain/Lump
- Breast Discharge Or Rash

NEUROLOGICAL:

- Frequent, Recurring Or Increasing Headaches
- Light-Headedness Or Dizziness
- Convulsions, Seizures, Spasms, Epilepsy
- Paralysis
- Stroke/TIA
- Head Injury

PSYCHIATRIC:

- Depression
- Anxiety/Agitation
- Crying For No Reason
- Insomnia
- Alcoholism
- Drug Problem (Now/Past)

ENDOCRINE:

- Glandular Or Hormone Problem
- Heat Or Cold Intolerance
- Excessive Skin Dryness
- Excessive Thirst Or Urination
- Weight Problem
- Diabetes
- Hypothyroidism/Goiter
- Hyperthyroidism

HEMATOLOGIC/LYMPHATIC:

- Recurrent Anemia
- Bleeding Or Bruising Tendency
- Swelling/Warmth/Tenderness Of Veins/Phlebitis
- Lumps Or Swollen Glands In Neck

IMMUNOLOGICAL:

- Immune System Disorder