Confidential Medical History

Your chief complaint or symptom: (Use back side of page if necessary)

Previous Diagnosis: (Use back side of page if necessary)

When and how did this condition begin? (Use back side of page if necessary)

Treatment you have received for this condition: (Use back side of page if necessary)

HEALTH HABITS	Yes	No	Frequency? (# of times per day/wk/mnth/yr)	Duration? (hrs/mins/days/years)
Do you exercise?				
Do you smoke?				
Do you drink alcohol?				
Substance Abuse?				

DIET Typical Breakfast	Typical Lunch?	Typical Dinner?	Typical Snacks/Drinks?

RECENT CONDITIONS OF…

___Dizziness / lightheadedness
___Fatigue
___Headaches (location:)
___Periods of unconsciousness
___Swelling or edema (where:)
___Swollen glands
___Trauma
___Other:

STRESS	Low	Med	High
Home			
Work			
Other			

List medications: (prescription, non-prescription and supplements. Use back side of page if necessary)

PAST ILLNESS

___Chicken pox
___Diphtheria
___mumps
___pneumonia
___Polio
___Rheumatic fever
___Rubella
___Scarlet fever
___Tetanus
___Trauma
___Herpes
___Venereal disease

PAST DIAGNOSIS

___AIDS/HIV
___Anemia
___Cancer (Type:)
___Cirrhosis
___Diabetes
___Epilepsy
___Heart attack
___Heart disease
___Hemophilia
___Hepatitis
___High blood pressure
___Mononucleosis
___Stroke
___Tuberculosis
___Anxiety disorders
___Depression
___Sexual/physical abuse
___Suicidal thoughts
___Epilepsy or seizures
___Osteoporosis

List surgeries or hospitalizations: Use back side of page if necessary)

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MARK ANY CONDITIONS RELATED TO YOU

EYES,EARS, NOSE, THROAT

___ dizziness
___ headache
___ change or loss in taste
___ cloudy vision
___ difficulty swallowing
___ discharge from ear
___ laryngitis / hoarseness
___ loss of smell
___ pain behind eyes
___ post-nasal drip
___ double vision
___ dry, red, or itchy eyes
___ bloody nose
___ blurry vision
___ earache
___ eye infection
___ glaucoma
___ hearing loss
___ recurrent sore throat / strep
___ sensation of lump in throat
___ sensitive to odors
___ sensitivity to light
___ sinus problems
___ spots before eyes
___ teeth grinding
___ thyroid problems
___ cataracts
___ ringing in the ears
  ___ intermittent
  ___ all the time
  ___ high pitched
  ___ low pitched

CARDIOVASCULAR

___ pain in arm, neck or mid-back
___ palpitations / irregular heartbeats
___ poor circulation in extremities
___ purple nails
___ swelling of hands, ankles or face
___ murmur
___ night sweats
___ varicose veins
___ high blood pressure
___ high cholesterol
___ chest pain - relieved by meds?
___ history of anemia
___ history of cardiac problems
___ leg cramps when walking
___ leg cramps at night
___ low blood Pressure
___ no difficulties

DIGESTION

number of meals/day __________
number of snacks/day __________
taste preference/cravings __________

___ bad breath
___ belching
___ bitter taste in mouth
___ bleeding gums
___ mouth sores
___ gallbladder problems
___ gas or gas pains
___ I am thirsty – (often) | (rarely)
___ appetite: (loss) | (excessive)
___ trouble digesting fats
___ pain / distention above navel
___ bloated sensation after meals
___ strong or aggressive hunger
___ nausea
___ 'noisy' stomach
___ indigestion
___ loss / change of taste
___ vomiting – what do you throw up?
____
___ heartburn / acid stomach
___ ulcers - what kind?
___ pain / cramping in intestines
___ rectal bleeding
___ no difficulties

RESPIRATORY SYSTEM

___ asthma
___ shortness of breath
  ___ worse with exertion
  ___ worse at night
___ pneumonia
___ sinus infection
___ bronchitis
___ Cough with phlegm (color?)
___ emphysema
___ I get cold easily
___ I sigh frequently
___ dry cough
___ nasal drainage
___ wheezing
___ no problems

URINATION

___ bed wetting
___ bladder / kidney infection
___ blood in urine
___ cloudy or dark urine
___ full feeling in bladder
___ small amount of urination
___ difficulty starting urination
___ frequent urination
___ gravel or stone(s) in urine
___ inability to urinate properly
___ incontinence / dribbling
___ painful or burning sensation
___ low flow
___ urgency
___ no difficulties
___ times you urinate per day
___ times you urinate at night

BOWEL HABITS

___ black, tarry stool
___ blood in stool
___ constipation
___ diarrhea / loose stool
___ hemorrhoids
___ I use laxatives
___ mucous in stool

My bowel movement are:
___ regular: ___ x daily
___ irregular: once every ____ days

MARK ANY CONDITIONS RELATED TO YOU

EMOTIONS

___ anger
___ depression
___ difficulty concentrating
___ fear
___ forgetfulness
___ general sadness
___ history of abuse
___ I can't let go
___ I feel stressed often
___ worry or anxiety
___ I have trouble making decisions
___ I over think things
___ irritability
___ nervousness
___ I generally feel fine

SLEEP PATTERNS

___ difficulty falling asleep
___ difficulty staying asleep
___ I take a sleep aid –?: ____________
What time sleep do your sleep problems seem to occur most?

____

___ excessive dreaming
___ nightmares
___ night sweats
___ no difficulties

BODY TEMPERATURES

___ afternoon feverishness
___ alternating chills & feverishness
___ I sweat without exertion
___ chills or sensations of chilliness
___ warm natured
___ fever or sensation of feverishness
___ I have night sweats
___ no problems

MUSCULOSKELETAL

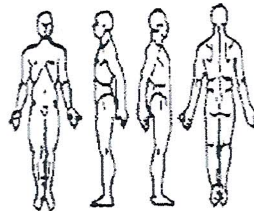
___ describe any sensation of...
burning, achy, sharp, shooting pain, numbness, tingling, radiating pain

___ Muscle cramps often - where?

___ joint swelling – where?

___ muscle pain / rheumatism – where?
___ tendonitis
___ arthritis – where?
___ bursitis – where?

Please mark problem areas on diagram:



SKIN, HAIR, NAILS

___ brittle nails
___ cuts heal slowly
___ dandruff
___ oily hair
___ dry skin – where?

___ hair loss
___ I bruise easily
___ itching
___ white spots on nails
___ dry hair
___ eczema /psoriasis
___ nails don't grow well
___ ridges of lines in nails
___ sore which doesn't heal
___ weepy sores
___ rashes – where?

FAMILY HISTORY						
Place an **'X'** for all that apply	father	mother	brother	sister	child	other
alcoholism						
asthma						
cancer: breast						
colon						
female organs						
prostate						
skin						
other						
depression, suicide, other mental illness						
diabetes						
glaucoma						
heart disease						
high blood pressure						
high cholesterol						
kidney disease						
migraines						
obesity or weight problems						
osteoporosis						
seizure						
thyroid disease						
other						

FOR WOMEN ONLY

Please fill in information for all that apply

Date of last pap smear ___/___/___

Date of last mammogram ___/___/___

Age you began menstruating? ___

Could you be pregnant now? yes | no

Number of past pregnancies? ___ miscarriages? ___

When did your last period end? ___/___/___

Number of days for monthly cycle? _______

Number of days bleeding lasts? __________

Menstrual flow? __heavy __moderate __mild __not present

__it varies, explain ____________________

Color of menstrual flow? __dark __bright red __slightly reddish

__other, explain ____________________

Age of menopause ___

Hysterectomy – ovaries removed: yes | no

Post-menopausal bleeding? yes | no

Do you use:

__birth control __barriers __ IUD

__no birth control __spermicidals

Notes:

Do you suffer from:

__**cramping:** if yes, __severe | __ moderate | __mild | __before period | __during period | __at the end of period

__**clotting:** if yes, __bright in color | __ dark in color

__**bleeding between periods** __**yeast infection / vaginitis / other discharge** __**mastitis** __**infertility**

__**breast cysts** __**hot flashes** __**pelvic inflammatory disease** __**ovarian cysts** __**endometriosis**

__**Premenstrual syndrome:** if yes,

__fluid retention | __ irritability | __fatigue | __fluctuating emotions | __cravings | __depression | __tenderness in breasts

__**clotting:** if yes, __bright in color | __ dark in color

__**bleeding between periods** __**yeast infection/vaginitis/other discharge** __**mastitis** __**infertility** **breast cysts**

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FOR MEN ONLY

__**impotence** __**infertility** __**premature ejaculation** __**testicular pain or lump** __**discharge from penis**

__**low sex drive** __**prostate problems** __**weak erection**

NOTES

Thank you for completing this form. Your time is greatly appreciated and I value this opportunity to serve you!