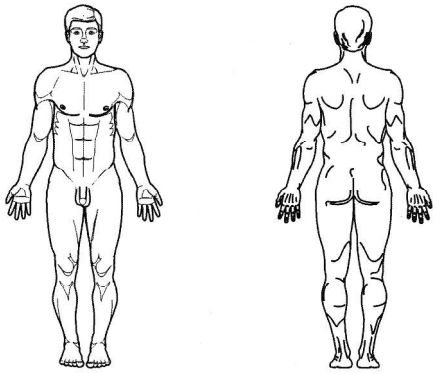
MEDICAL HISTORY QUESTIONAIRRE
Please complete the following as accurately as possible

NAME: _____ DATE: ___/___/_____

Present Illness:

What is your chief complaint?

Please Mark an "X" Where You Feel Pain or Discomfort



When/How did this condition develop?

What treatment have you received already?

Is there anything that makes it worse or better?

Medical History:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had?

Do you have any allergies that you know?

Medication Info: Please list all current medication or supplements

Start Date	Medication	Dosage	Frequency	Reason	Last Dose

Have you had any courses of antibiotics recently? Many Few 1 or 2 None Why? _____

Which, if any, of your <u>blood relatives</u> have had any of the following?

☐ Stroke ☐ Tuberculosis

☐ High Blood Pressure ☐ Bleeding Disorders

☐ Heart Disease ☐ Diabetes

☐ Cancer Type _____ Relation _____

MEDICAL HISTORY QUESTIONAIRRE (cont.)

Habits

Do you have a regular exercise program? Please describe: _____

_____

Please indicate usage per day or per week:

Cigarettes _____ per _____ Tea _____ per _____

Alcohol _____ per _____ Soft Drinks _____ per _____

Drugs _____ per _____ Sugar _____ per _____

Coffee _____ per _____ Other _____ per _____

Please describe your average daily diet:

Morning: _____

Afternoon: _____

Evening: _____

Are you or have you been on a restricted diet? What kind and why? _____

_____

What are your favorite foods? _____

Are there any foods that you particularly dislike? _____

Are you happy with your current body weight? Yes No

Have you had any significant weight change: Yes No Explain: _____

_____

How many hours of sleep do you get per night: _____ What time do you usually go to sleep: _____

Do you have problems either: Falling asleep Staying asleep

Do you wake feeling rested: Yes No Do you have adequate energy throughout the day: Yes No

List one or two emotions that are predominate in your life, and which are either frequently experienced or difficult to express: _____

Female

Number of pregnancies _____ Number of births _____

Number of abortions _____ Age of menopause _____

Age of first menses _____ Number of days between menses _____

Duration of menses _____ First day of last menses _____

Any vaginal discharge _____ Are you on birth control ? Y or N

Date of last PAP _____ What type and for how long _____

NAME: _____ DATE: ____/____/_____

CHECK ANY CURRENT CONDITIONS OR THOSE THAT YOU HAVE HAD IN THE PAST
(Please write the letter "P" next to those conditions which you have ONLY had in the past and which are no longer present.)

HEAD & NECK:
____ Dizziness
____ Fainting
____ Neck Stiffness
____ Enlarged Lymph Glands
____ Headaches
_____ Other

EARS:
____ Infection
____ Ringing
____ Decreased Hearing
_____ Other

NOSE, THROAT & MOUTH:
____ Bleeding
____ Sinus Infection
____ Hay Fever or Allergies
____ Sore Throat
____ Hoarseness
____ Changes in Taste
____ Difficulty Swallowing
____ Changes in Smell
____ Oral Ulcers / Canker Sores
_____ Other

SKIN:
____ Hives
____ Rash
____ Eczema
____ Psoriasis
____ Seborrhea
____ Night Sweating
____ Excess Sweating
____ Dryness
____ Bruises Easily
____ Changes in Moles or Lumps
_____ Other

NEUROLOGICAL:
____ Numbness or Tingling of Limbs
____ Seizures
____ Tremors
____ Pain
____ Paralysis
____ Epilepsy or Convulsions
_____ Other

INFECTION SCREENING
____ HIV/AIDS or HIV Risk: Self or Partner
____ Hepatitis or Hepatitis Risk: Self or Partner
____ TB: Self or Partner
____ History of Sexually Transmitted Diseases: Self or Partner
____ Gonorrhea
____ Chlamydia
____ Syphilis
____ Genital Warts
____ Herpes: Oral or Genital (Circle 1 or Both)

RESPIRATORY
____ Chronic Cough
____ Coughing Up Blood
____ Coughing Up Phlegm
____ Difficulty Breathing
____ Wheezing / Asthma
____ Frequent Colds
____ Emphysema
____ Pneumonia repeatedly
_____ Other

CARDIOVASCULAR
____ Palpitations
____ Chest Pain or Tightness
____ Rapid Heart Beat
____ Irregular Heart Beat
____ Heart Disease
____ Poor Circulation
____ Swelling of Ankles
____ Phlebitis
____ Cold Hands / Feet
____ High Blood Pressure
____ Stroke
_____ Other

GASTROINTESTINAL:
____ Indigestion
____ Nausea
____ Stomach Pain
____ Irritable Bowel Disease (IBS)
____ Colitis
____ Crohn's Disease
____ Pancreatitis
____ Celiac Disease
____ Recent Change in Bowel Habits
____ Diarrhea (_____ stools / day)
____ Constipation (_____ stools / day)
____ Hard, Dry Stools
____ Soft, Difficult, or Sticky Stools
____ Irregularity or Poorly Formed Stools
____ Poor Appetite
____ Excessive Hunger
____ Bad Breath
____ Blood in Stools or Black Stools
____ Hemorrhoids
____ Gall Bladder Disorder
____ Vomiting Blood
____ Peptic Ulcer
____ Recent Change in Weight
____ Food Cravings

MUSCLE & JOINTS:
____ Joint Disorder:
Please specify: _____
____ Sore Muscles
____ Weak Muscles
____ Difficulty Walking
____ Spinal Curvature
____ Backache
____ Back Pain
____ Fibromyalgia
_____ Other

MALE:
____ Pain / Itching of Genitalia
____ Genital Lesions / Discharge
____ Impotence
____ Premature Ejaculation
____ Prostate Problems
____ Infertility (ie. abnormal sperm)
_____ Other

FEMALE:
____ Vaginal Itching
____ Infertility
____ Pain / Itching of Genitalia
____ Genital Lesions / Discharge
____ Abnormal Pap Smear
____ Pelvic Inflammatory Disease
____ Irregular Periods
____ Emotional Changes w/ Menses
____ Clots w/ Menses
____ Painful Menstrual Period
____ Abnormal Bleeding
____ Breast Swelling and/or Pain
_____ Other

URINARY:
____ Frequent Urinary Tract / Bladder Infection
____ Weak Urinary System
____ Recent Changes in Bladder Habits
____ Kidney Disease
_____ Other

GENERAL:
____ Fatigue
____ Excessive Thirst
____ Aversion to Cold or Wind
____ Insomnia
____ Frequent Vivid Dreams / Nightmares
____ Depression
____ Agitation / Anxiety
____ Irritability / Anger
____ History of Psychiatric Treatment
____ Poor Memory: Short or Long Term
____ Difficulty Concentrating
____ Frequent Nigh Urination (_____ night)
____ Frequent Day Urination (_____ day)
____ Anemia
____ Congenital Abnormalities
____ Surgical Implants
____ Lupus Erythematosis
____ Jaundice
____ Hernia
____ Epstein Barr Virus (EBV)
____ Rheumatic Fever
____ Diabetes Mellitus
____ Thyroid Disorder: Hypo or Hyper
____ Cancer