**Medical History Form**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Date |  |  | Time of Birth |  |  |
| Name |  | Age | Date of Birth | Sex | |
| Address |  |  |  | City | |
| State |  | Zip | Phone (home) |  |  |
| Work Phone |  |  | Cell Phone |  |  |
| Occupation |  |  | Education |  |  |
| Full Time | Part time | Unemployed | Retired | Disabled | |
|  | |  |  |  |  |
| Members of Household | | Age/Date of birth |  | Relationship |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |



**What are your most important health care problems? Please list in order of importance** 1

2

3

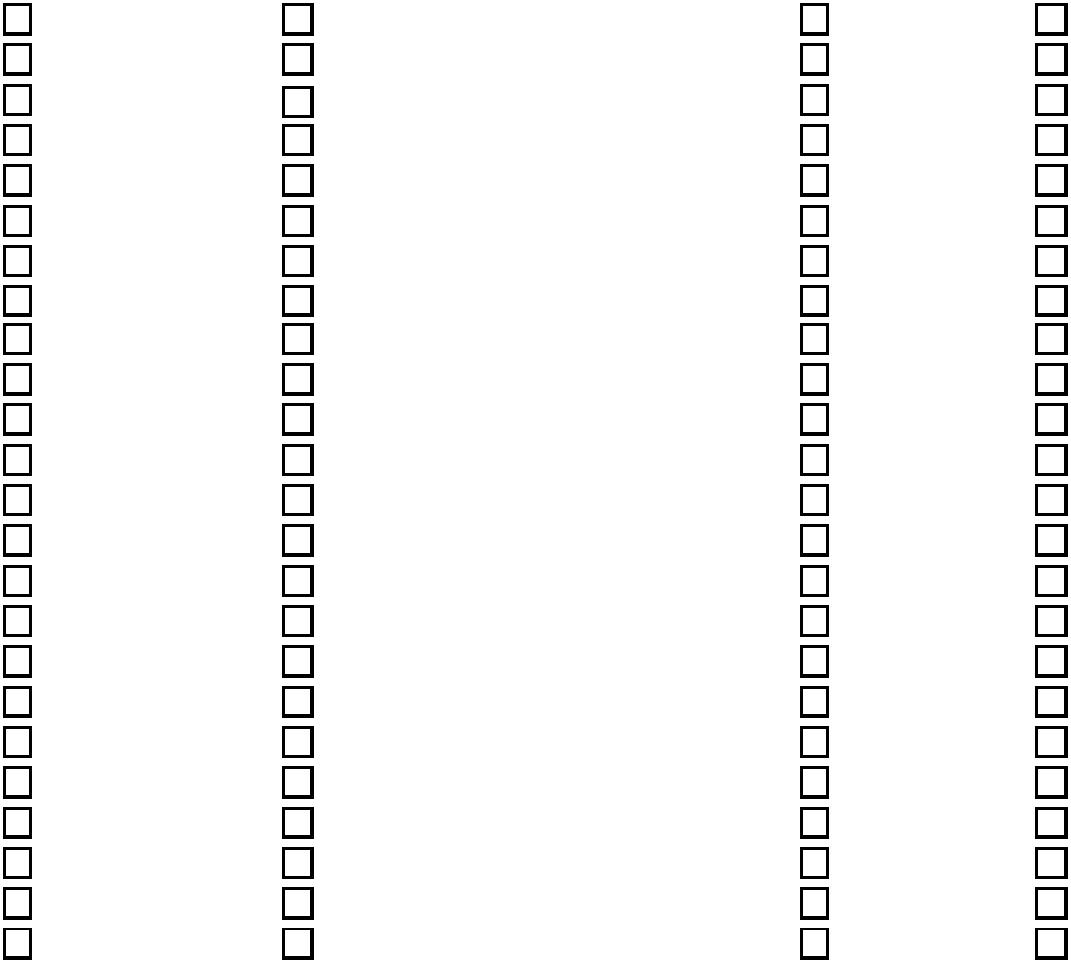
4

5

6

**Have you had any of the following medical conditions? (check all that apply)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Now** | **Past** | **Now** | **Past** |
|  | AIDS |  | Bleeding |
|  | Alcohol Abuse |  | Cancer |
|  | Allergies |  | Colitis |
|  | Anemia |  | Cohn's Disease |
|  | Anorexia |  | Depression |
|  | Arthritis |  | Diabetes |
|  | Asthma |  | Diarrhea |
|  | Bulimia |  | Drug Abuse |
|  | Dysentery |  | Meningitis |
|  | Easy Bruising |  | Mental illness |
|  | Eczema |  | Migraines/Headaches |
|  | Emphysema |  | Nervous breakdown |
|  | Epilepsy/Seizures |  | Obesity |
|  | Food Poisoning |  | Pneumonia |
|  | Gallstones |  | Polio |
|  | Gout |  | Psoriasis |
|  | Gum/Tooth Disease |  | Stroke |
|  | Hypertension |  | Syphilis |
|  | Infections, Chronic |  | Thyroid problems |
|  | Kidney Disease |  | Tuberculosis |
|  | Liver disease |  | Tumors |
|  | Lung disease |  | Typhoid |
|  | Malaria |  | Ulcers |
|  | Malnutrition |  | Worms |
| **Trauma History** | **List any abuse, major accidents, head injuries, falls, blows, etc.** | | |



\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Any loss of consciousness? | Yes | No | Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Hospitalizations** |  |  |  |
| **Illnesses/Inpatient or outpatient surgery** | |  | **Date** |



Any history of animal bites? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of current prescription medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any history of allergic reactions to medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

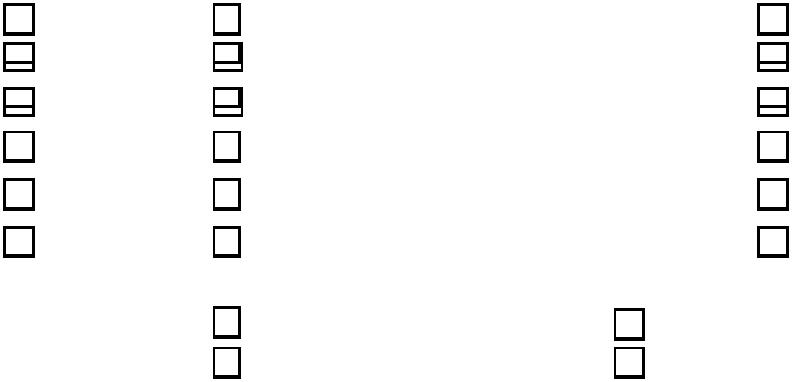
List of any current or previous homeopathic remedies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of current vitamins and supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of any other current medical or health treatments (e.g. acupuncture, massage, dental) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check any of the following that you use. How much of each for how long?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| coffee | | |  | Marijuana |  | sleeping pills |  |
| tea |  |  |  | recreational drugs |  | thyroid replacement |  |
|  |  |  |  |
| cigarettes/cigars |  |  |  | aspirin |  | hormone replacement |  |
|  |  |  |  |
| snuff/chewing tobacco | | |  | Tylenol |  | birth control pills |  |
| alcohol | | |  | ibuprofen |  | Chinese herbs |  |
| soft drinks | | |  | laxatives |  | herbs |  |
| Do you use an electric blanket? | | |  | Yes |  | No |  |
| Do you get regular exercise? | | |  | Yes |  | No Is so, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |



Any special diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY**

**major illness/ cause**

**Relation** **Living** **Dead** **Age** **of death**

Mother



Father



Brother(s)



Sister(s)



Maternal grandmother



Maternal grandfather



Paternal grandmother

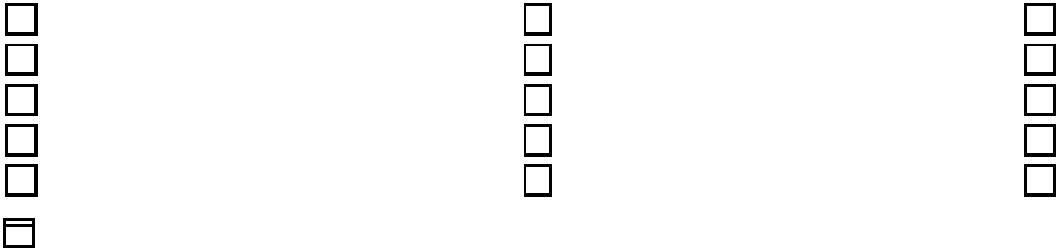


Paternal grandfather



**Please check any of the following that have occurred in your blood relatives**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| heart disease |  | stroke | neurological disorder |  |
| kidney disease |  | glaucoma | suicide |  |
| seizures/epilepsy |  | mental illness | depression |  |
| hypertension |  | cancer | alcoholism |  |
| thyroid disease |  | tuberculosis | drug abuse |  |
| diabetes |  | sexually transmitted disease (e.g. syphilis, gonorrhea, AIDS) | |  |
|  |  |



**Birth and development history**

Did your mother have any problems during pregnancy?

Problems during labor and delivery?

Was there any delay in your walking or talking?

was there any prolonged bed-wetting?

**Childhood illnesses (please check all you have had)**

rubella  rheumatic fever 

measles 

mumps



whooping cough

chickenpox



scarlet fever



polio



**Immunization history (please check all you have had)**

DPT 

smallpox 

pneumovax 

Polio

measles/mumps



/rubella

TB 

hepatitis 

Flu

Did you have any bad reactions or chronic illnesses following immunizations? Yes  No



If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your hobbies and interests:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Favorite books: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Favorite movies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mental symptoms (check any symptoms that are strong, chronic or feel significant to you)**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | **Now** | **Past** | | | **Now** | **Past** |  |  |
|  |  |  |  | absent minded | |  |  | lazy |  |
|  |  |  |  | angered easily | |  |  | lonely |  |
|  |  |  |  | annoyed by little | |  |  |  |  |
|  |  |  |  | things | |  |  | memory problems |  |
|  |  |  |  |  |  |  |  | mental mistakes |  |
|  |  |  |  | anxiety | |  |  | (dyslexia, etc.) |  |
|  |  |  |  | competitive | |  |  | mood swings |  |
|  |  |  |  | concentration | |  |  |  |  |
|  |  |  |  | difficulties | |  |  | nail biting |  |
|  |  |  |  | consolation desired | |  |  | nervousness |  |
|  |  |  |  | consolation not | |  |  |  |  |
|  |  |  |  | wanted | |  |  | nightmares |  |
|  |  |  |  | critical | |  |  | obstinate |  |
|  |  |  |  | depression/ | |  |  |  |  |
|  |  |  |  | prolonged sadness | |  |  | obsessive thinking |  |
|  |  |  |  | dwelling on past | |  |  | relaxation difficulties |  |
|  |  |  |  | euphoria | |  |  | restlessness |  |
|  |  |  |  | hallucinations | |  |  | revengeful |  |
|  |  |  |  | hearing voices | |  |  | shy/timid |  |
|  |  |  |  | hopeless outlook | |  |  | sloppy/ messy |  |
|  |  |  |  | hurried/ | |  |  |  |  |
|  |  |  |  | hyperactive | |  |  | startle easily |  |
|  |  |  |  | impatient | |  |  | suspicious |  |
|  |  |  |  | increased | |  |  |  |  |
|  |  |  |  | irritability | |  |  | temper |  |
|  |  |  |  | indecisive | |  |  | tidy/fastidious |  |
|  |  |  |  | indifferent/ | |  |  |  |  |
|  |  |  |  | apathetic | |  |  | weep easily/frequently |  |
|  |  |  |  | insomnia | |  |  | worry, excessive |  |
|  |  |  |  | jealousy | |  |  |  |  |
|  | **Fears (Please check any significant)** | | | |  |  |  |  |  |
|  |  |  |  |  | |  |  |  |  |
|  |  | accidents |  | devil | |  | hurting others | rejection |  |
|  |  | appearing in |  |  |  |  |  |  |  |
|  |  | public |  | disease | |  | injury | robbers |  |
|  |  | being |  |  |  |  |  |  |  |
|  |  | alone |  | dogs | |  | insects | snakes |  |
|  |  | birds |  | failure | |  | insanity | spiders |  |
|  |  | blood |  | fainting | |  | knives | storms |  |
|  |  | bridges |  | flying | |  | mice | strangers |  |
|  |  | cancer |  | future | |  | monsters | sudden noises |  |
|  |  | cats |  | ghosts | |  | narrow places | suffocation |  |
|  |  | crowds |  | health of family | |  | opposite sex | thunderstorms |  |
|  |  | dark |  | heart disease | |  | people | tunnels |  |
|  |  | death |  | heights | |  | poverty | of unknown |  |
|  |  | deep water |  |  |  |  | public speaking | violence |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |



**Please list any other fears you may have: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are there experiences in your life that have had a lasting effect or from which you have never recovered?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**General symptoms: How do you react to the following conditions? (check all that apply)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Not affected by** | **Worse from** | **Dislike** | **Better from** | **Like/prefer** |
| humidity |  |  |  |  |  |
| wind |  |  |  |  |  |
| draft |  |  |  |  |  |
| heat |  |  |  |  |  |
| cold |  |  |  |  |  |
| rain |  |  |  |  |  |
| fog |  |  |  |  |  |
| sun |  |  |  |  |  |
| change in temperature |  |  |  |  |  |
| change of season |  |  |  |  |  |
| summer |  |  |  |  |  |
| winter |  |  |  |  |  |
| spring |  |  |  |  |  |
| autumn |  |  |  |  |  |
| sleep |  |  |  |  |  |
| afternoon nap |  |  |  |  |  |
| lying down |  |  |  |  |  |
| sitting |  |  |  |  |  |
| standing |  |  |  |  |  |
| running |  |  |  |  |  |
| climbing stairs/hills |  |  |  |  |  |
| exercise in general |  |  |  |  |  |
| eating |  |  |  |  |  |
| talking |  |  |  |  |  |
| touch |  |  |  |  |  |
| tight cloths |  |  |  |  |  |
| warm bath/shower |  |  |  |  |  |
| cold bath/shower |  |  |  |  |  |
| full moon |  |  |  |  |  |
| being near or in ocean |  |  |  |  |  |
| being in the mountains |  |  |  |  |  |



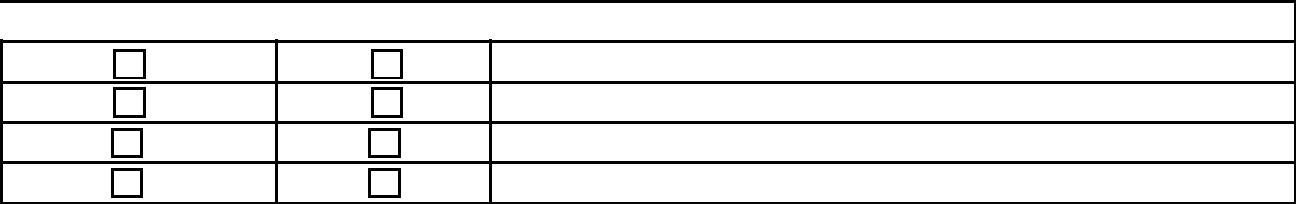
Music - What Types? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Strongly sensitive to: (please check all that apply)**

|  |  |
| --- | --- |
| noise | pollen |
| dust/mold | odors in general |
| getting feet wet | cigarette smoke |
| exhaust | other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| perfume |  |



**Have you had:**



**Now** **Past**

large weight gains

large weight losses

chronic fatigue

weakness

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you have a dip in energy at regular times every day or night? | Yes |  | No |  |
|  |  |



If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time of day do you have your best energy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any periodic symptoms that come at regular intervals? Yes  No



If so, what ate they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Sleep**



**Now** **Past**

Difficulty falling asleep

jerking, on falling asleep

interrupted sleep

sleep walking

talking in sleep

grinding teeth in sleep

Favorite sleep positions(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Staycovered during the night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stick feet out from covers? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

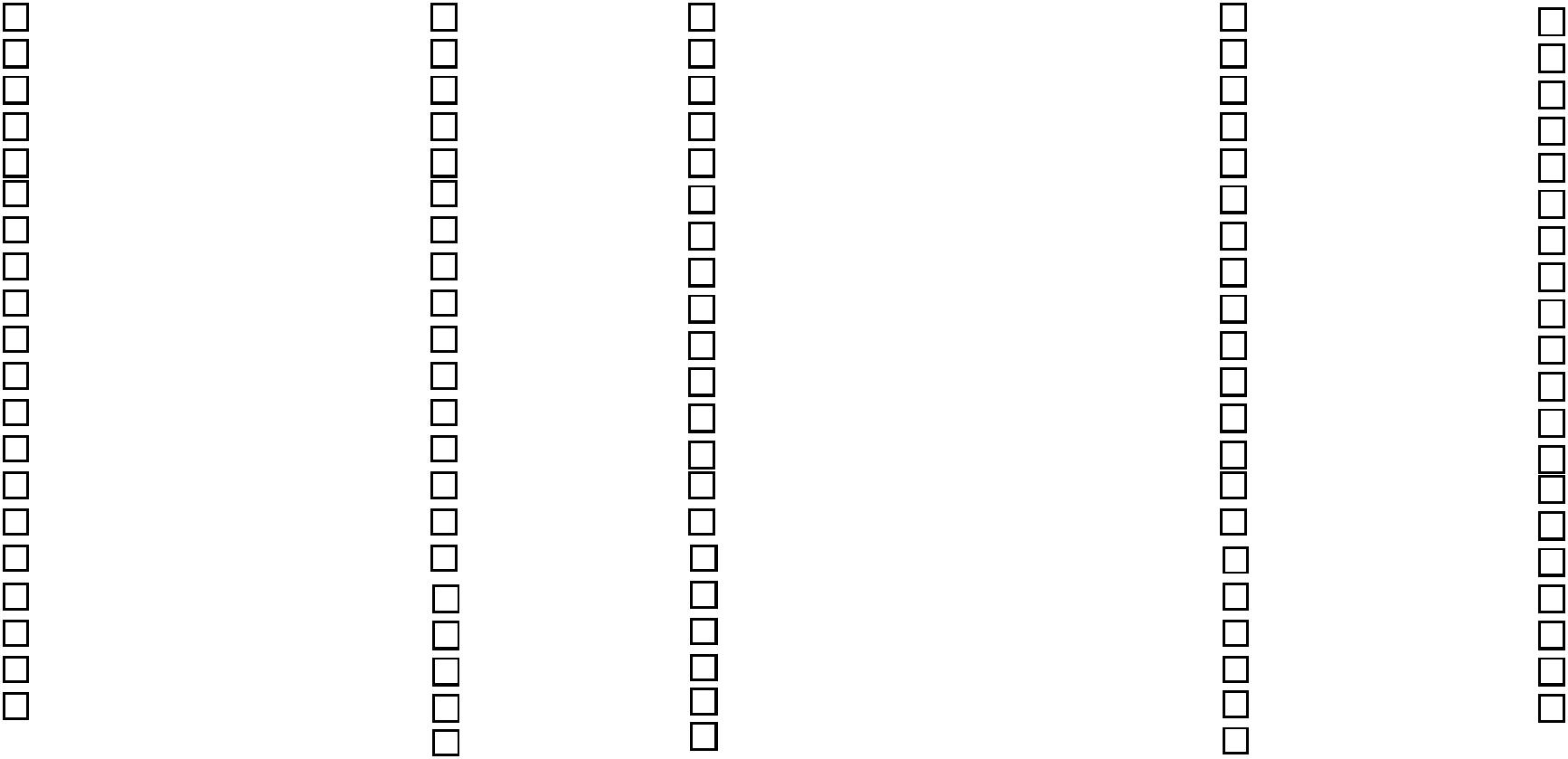
Wear socks to bed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Feeling on waking in the morning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Feeling on waking from nap \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dreams (please check any dreams you have had)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| animals | desert | missing train | poison | praying |
| cats | ocean | unprepared | intrigue | religious |
| dogs | river | grief | talking | spiritual |
| horses | snow | weeping | singing | god |
| insects | death | vexation | dancing | house of worship |
| wild animals | dead bodies | quarrels | business | remote events |
| worms | body parts | jealousy | money | recent events |
| snakes | suicide | insults | day's work | future events |
| robbers | hunger | misfortunes | physical work | prophetic |
| thieves | thirst | insecurity | vomiting | children |
| ghosts | eating | danger | passing stool | parties |
| traveling | drinking | pursuit | urinating | birth |
| flying swimming | foods | accidents | bleeding | wedding |
| riding/driving | fruit | falling | pain | funerals |
| drowning | fire | shooting | illness | the dead |
| houses | lightening | rape | sickness | fatigue |
| buildings | storms | wars | mutilation | fearful |
| bridges | rain | police | romantic | anxious |
| trees | failure | imprisonment | erotic | happy |
| mountains | exams | cries | sexual pleasure | ecstatic |
|  | failing effort | murder | nakedness |  |



Have you had any recurring dreams? If so, please describe

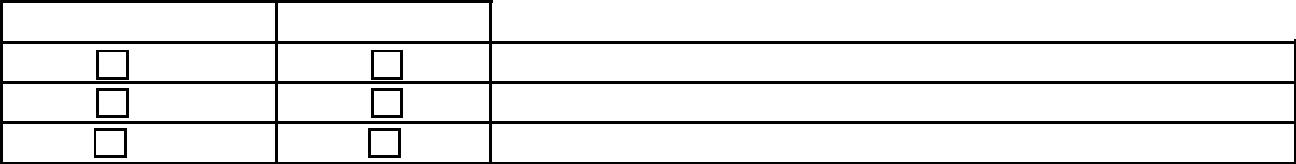
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please elaborate on any dreams that have made a strong impression on you:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Perspiration**



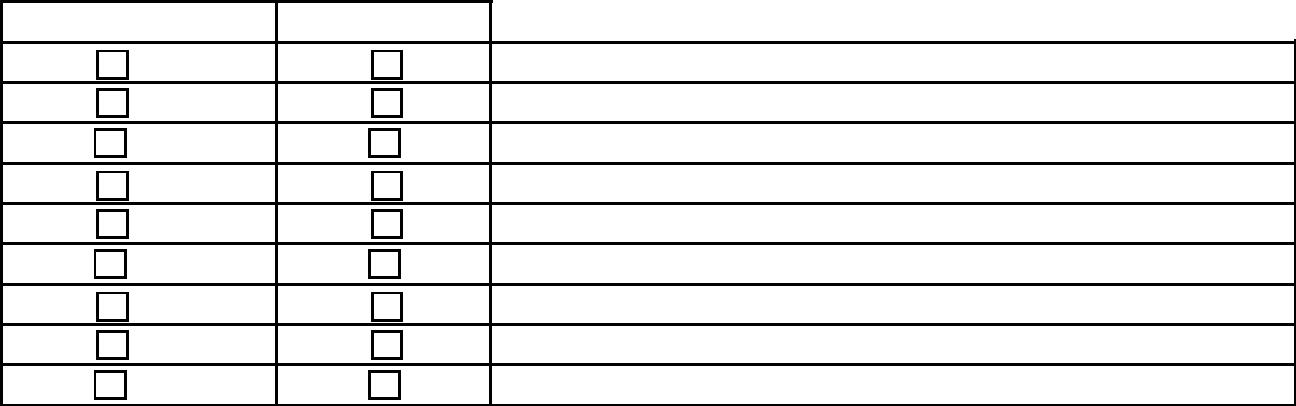
**Now** **Past**

excessive sweating; specify part of body

strong odor of perspiration

night sweats

**Head symptoms**



**Now** **Past**

hair loss

dandruff

heaviness

constriction

headaches, location:

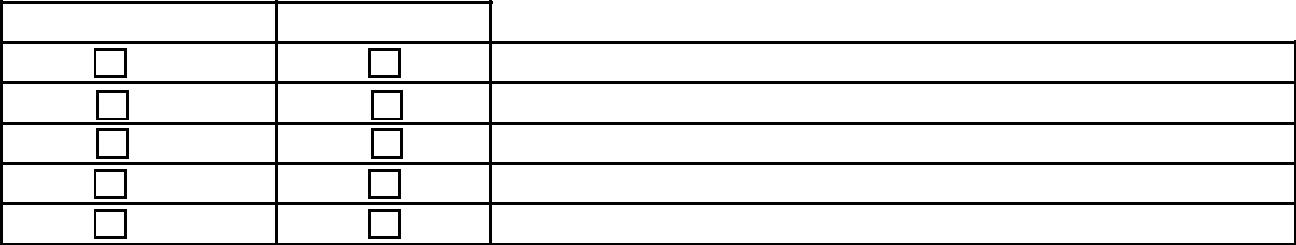
sensitive scalp

eruptions

aversion to hats

marked sweating, location:

**Vertigo**



**Now** **Past**

loss of balance

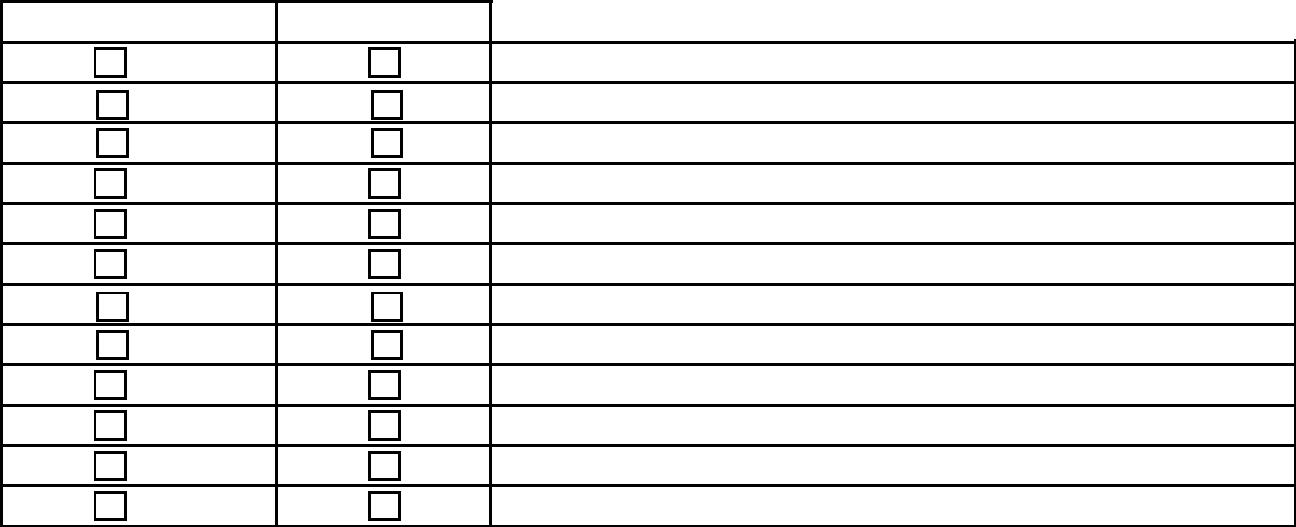
fainting spells

dizziness

discomfort with heights

car/sea/motion sickness

**Eye symptoms**



**Now** **Past**

poor eyesight

blindness

aversion to sun

double vision

eye infections

itchy eyes

sensation of sand in eyes

sties

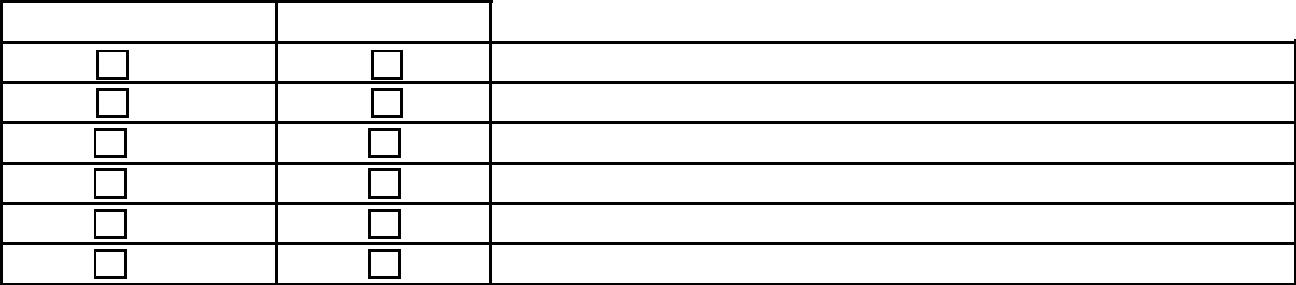
see halos, spots or lights

pain in eyes

excessive tearing

redness

**Ear symptoms**



**Now** **Past**

discharge from ears

pain in ears

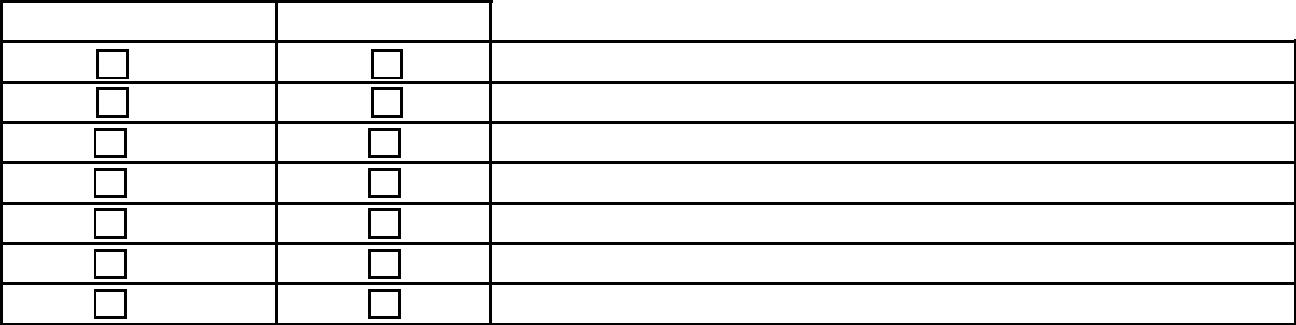
chronic ear infections

ringing /noises in ears

hearing loss

itching in ears

**Nose symptoms**



**Now** **Past**

nose bleeds

loss of smell

congestion

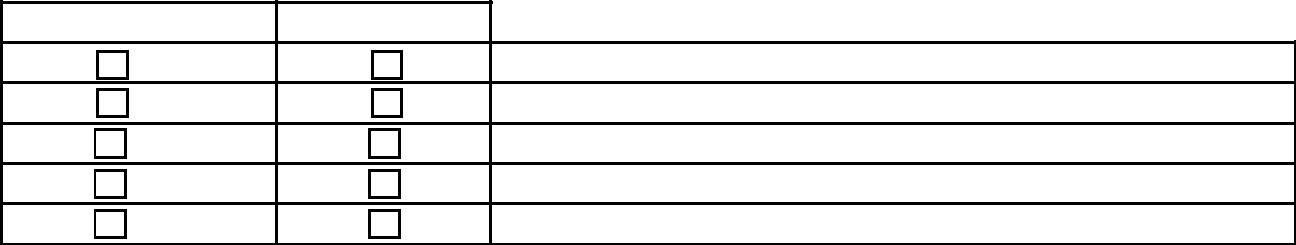
sinus infections

breathing problems Day Night

frequent sneezing

eruptions/sores

**Facial symptoms**



**Now** **Past**

pain/neuralgia

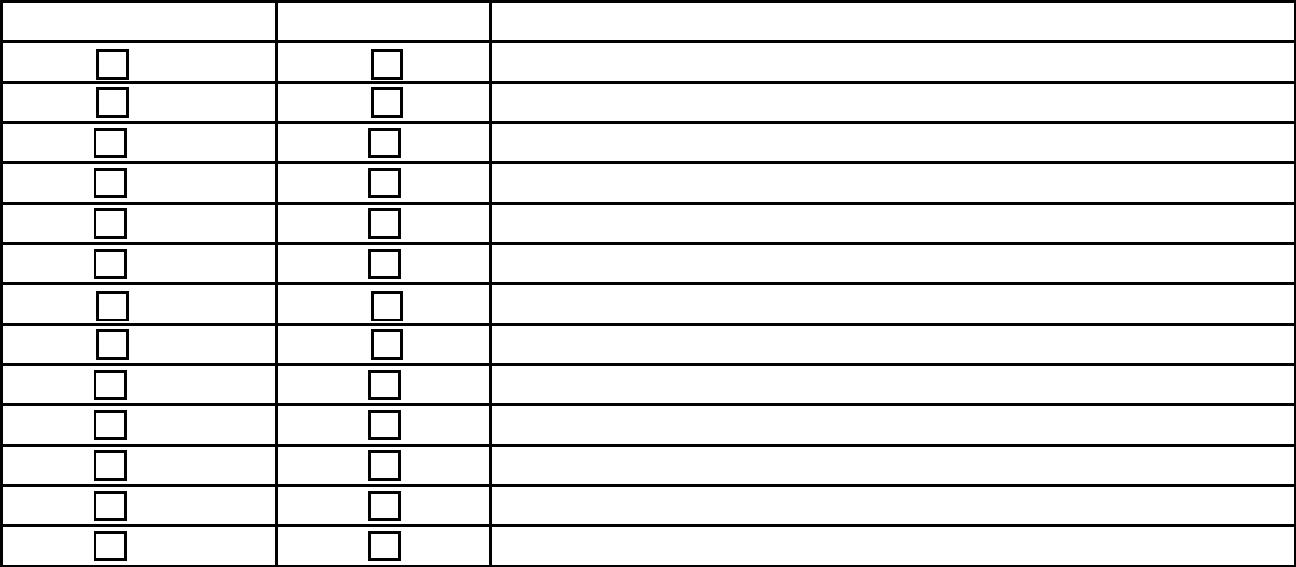
acne

twitching

excessive sweating

discoloration Which color?

**Mouth/Teeth symptoms**



**Now** **Past**

gum infections

bleeding gums

fever blisters

bad breath

caner sores

many dental cavities

tooth sensitivity

TMJ pain

cracked lips

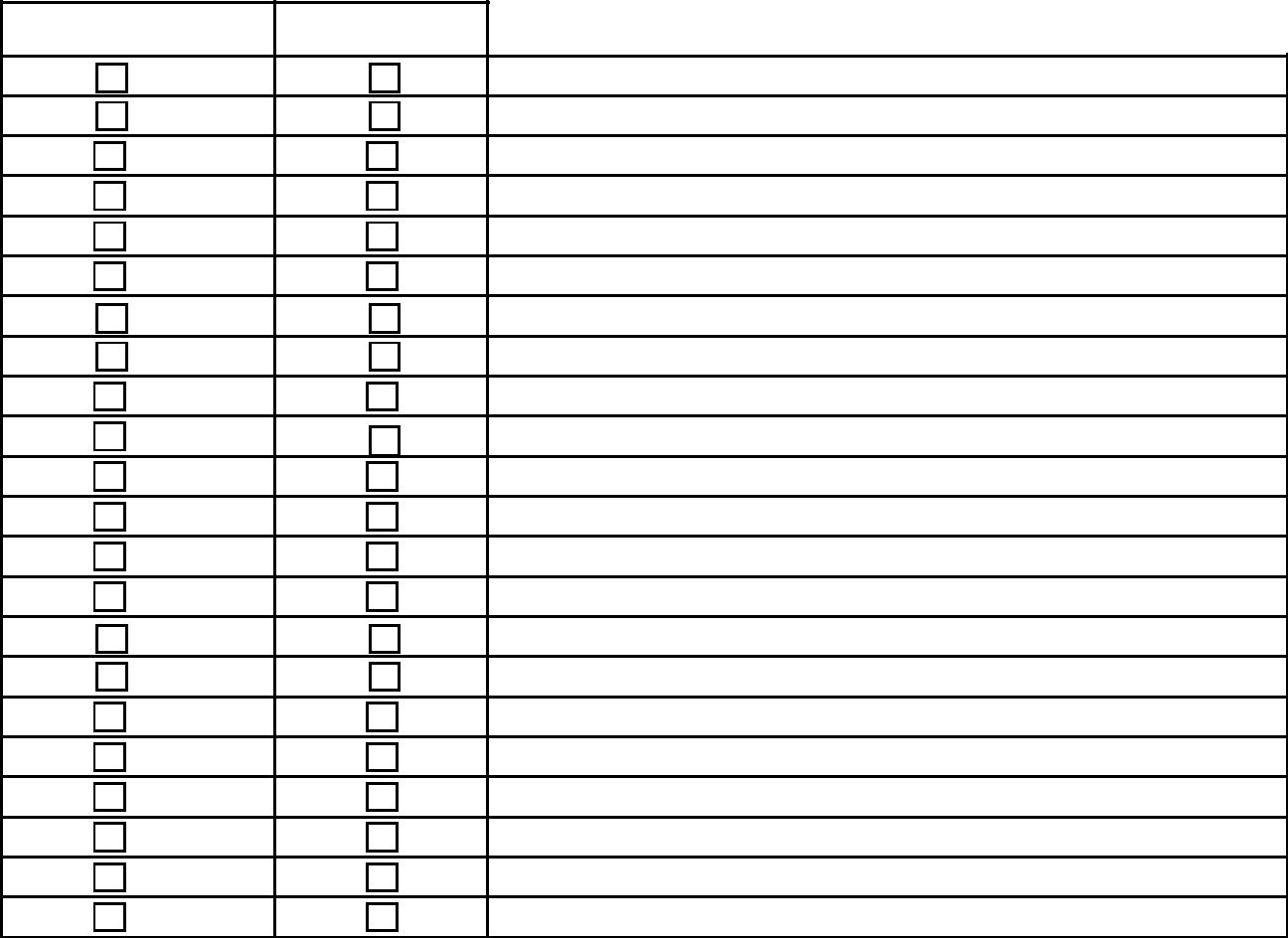
cracking jaw

peculiar taste, please describe:

cracks on tongue

excessive salivation Day Night

**Digestive symptoms**



**Now** **Past**

heartburn

indigestion

frequent nausea

recurrent vomiting

diarrhea

constipation

bloody stool

light colored stool

rectal pain

rectal itching

worse from missing a meal

bloating

belching

flatulence/passing gas

marked thirst

thirst less

appetite increased

appetite decreased

hurried eating

loss of taste

difficulty swallowing

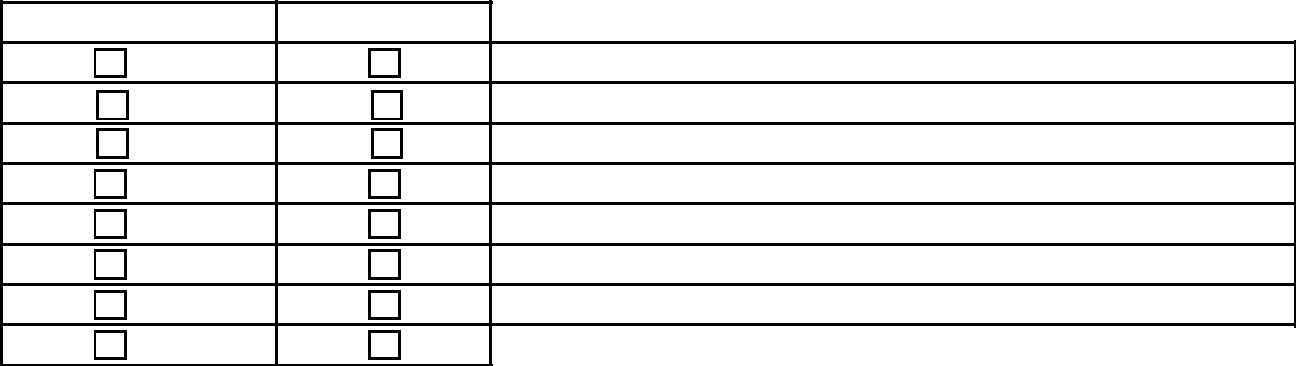
abdominal or stomach pain

Do you have a strong desire for any particular food? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you strongly dislike any particular food? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any foods which make you feel bad or aggravate any of your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Urogenital symptoms**



**Now** **Past**

frequent urination

painful urination

difficult urination

involuntary urination

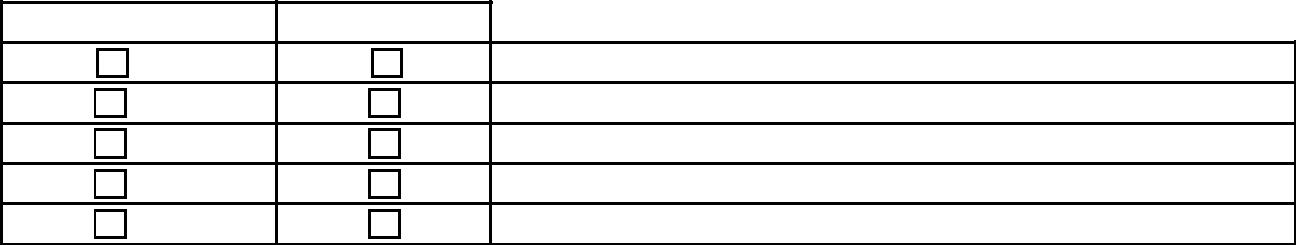
strong smelling urine

blood in urine

frequent masturbation

change in sexual energy Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Male symptoms**



**Now** **Past**

difficult or loss of erection

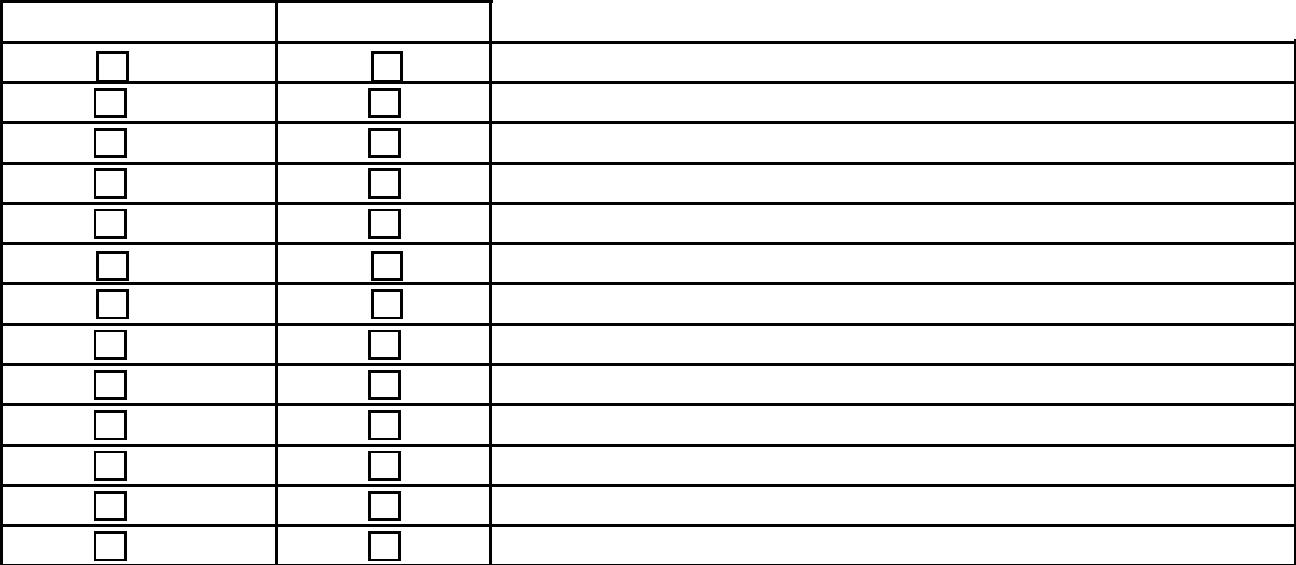
painful erections

discharges

lumps or swelling in the testicles

infertility

**Female symptoms**



**Now** **Past**

vaginal infections/discharge

vaginal itching

cervical problems

irregular periods

bleeding between menstrual periods

infertility

PMS

excessive menstrual flow

vaginal dryness

few or no orgasms

pain in breasts

swelling or lumps in breasts

discharge form breasts

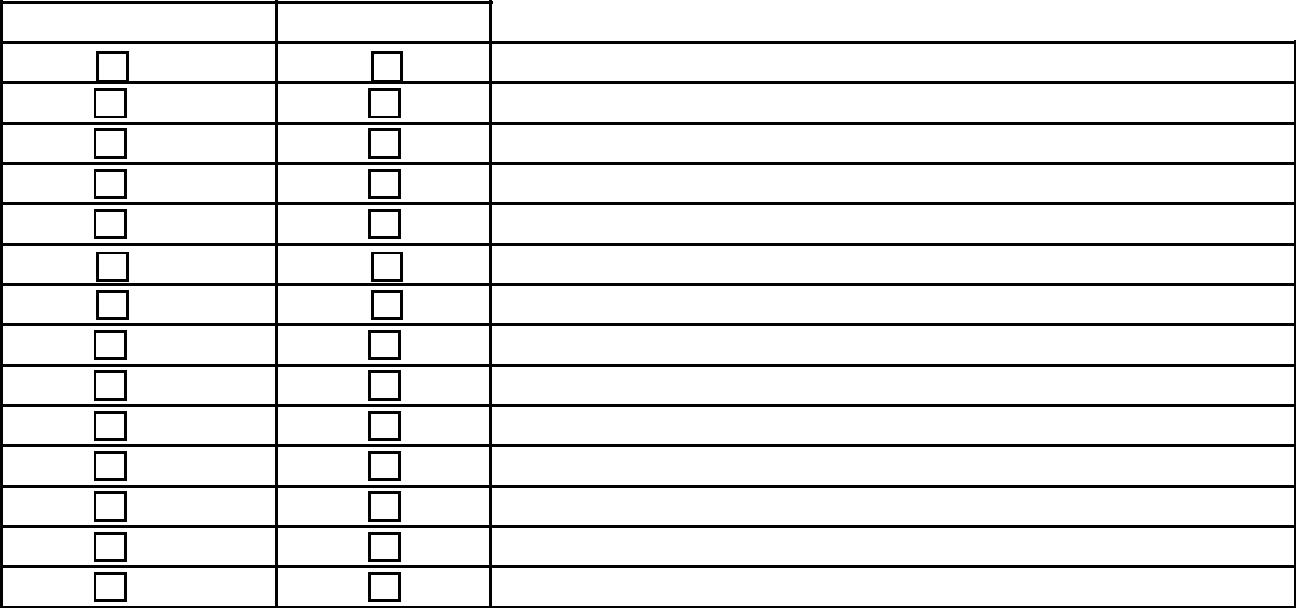
When did you begin menstruating? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long do your periods usually last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Number of pregnancies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Number if births: \_\_\_\_\_\_\_\_\_\_ | | Caesareans: \_\_\_\_\_\_\_\_ |
| Miscarriages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Abortions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |  |
| Any complications during pregnancy? | Yes | No | If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Did you breastfeed your children? | Yes | No | If so, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |



**Respiratory symptoms**



**Now** **Past**

Persistent/recurrent hoarseness

loss of voice

persistent throat pain

chronic throat infections

swollen tonsils

frequent chest colds

wheezing

persistent cough

coughing up mucus

coughing up blood

pain on breathing

difficulty breathing when walking

difficulty when climbing stairs

difficulty when lying

**Cardiovascular symptoms**



**Now** **Past**

palpitations

chest pain at rest

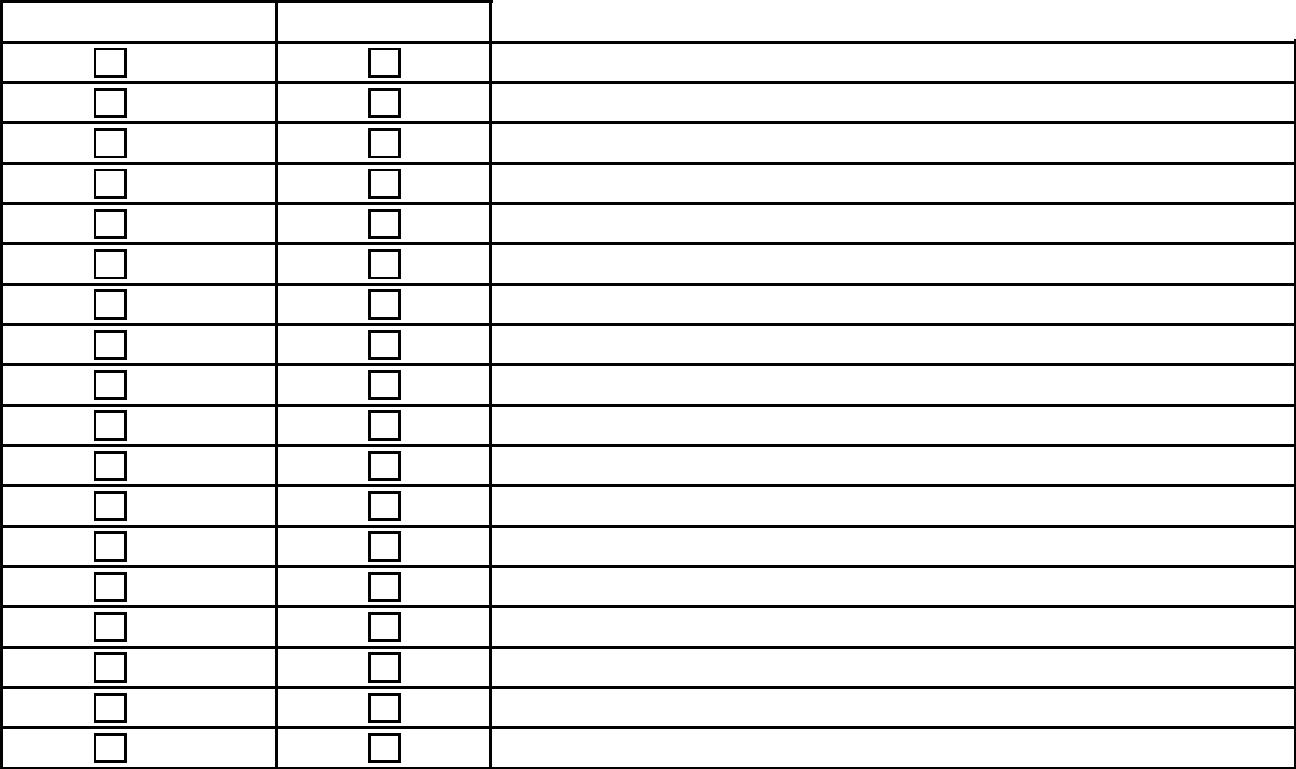
chest pain with walking/exertion

ankle or leg swelling

leg pain unrelated to injury

easy bruising or bleeding, from where?

**Skin symptoms**



**Now** **Past**

rough skin, dry skin

itching

rashes

moles

nail changes

shingles/herpes

pimples

boils

warts

cysts

infections

hives or urinary

swollen glands, location?

eczema, location?

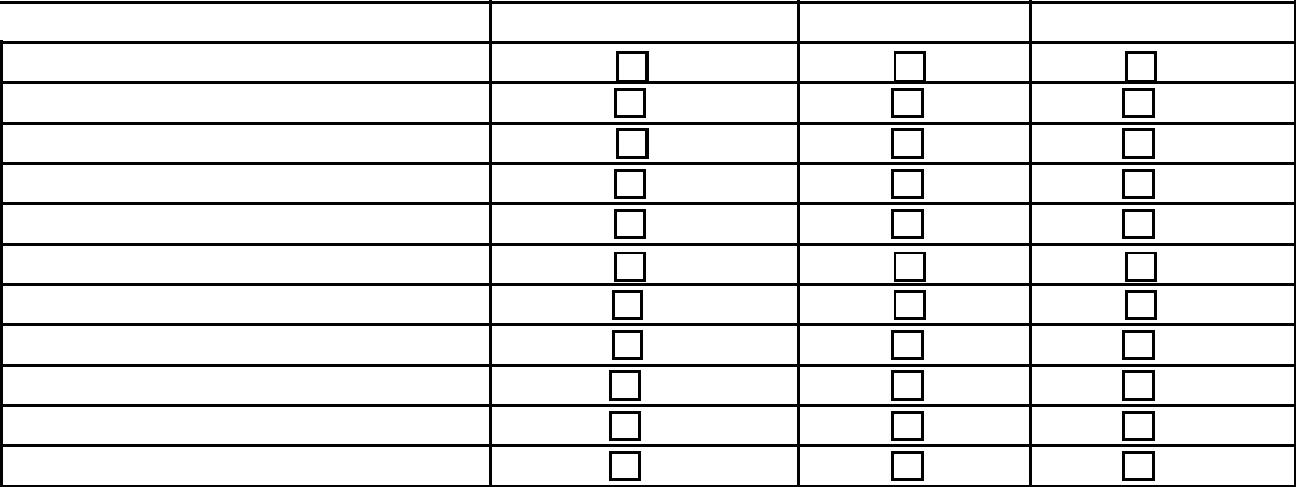
pustules

discoloration, what color?

easy bruising

skin cracks, location?

**Musculoskeletal symptoms**



|  |  |  |
| --- | --- | --- |
| **Now** | **Past** | **Location** |

pain

stiffness

swelling

numbness

tightness

burning/heat

coldness

twitching

tremors

weakness

paralysis

Please list any symptoms not covered in the sections above, or add any information to help:

Clarify your history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_