
Patient Medical History Form

Date _____

Patient Name _____

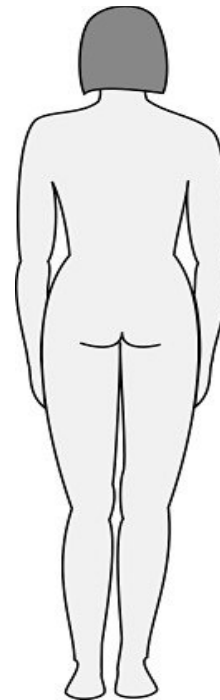
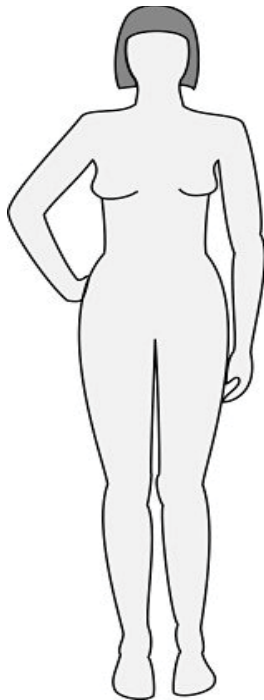
Present Illness _____

Yes No

- Do you experience pain every day?
- Do your symptoms interfere with daily life?
- Does pain wake you up at night?
- Are your symptoms worse during certain times of the day?
- Do changes in weather affect your symptoms?

What activities aggravate your symptoms? _____

Please use the following letters to indicate TYPE and LOCATION of the symptoms you currently are experiencing. **A**=Ache **B**=Burning **P**=Pins & Needles **N**=Numbness **S**=Stabbing **O**=Other



Medical History. Please check any disease or condition you have had in the past or have now:

<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Migraine headache	<input type="checkbox"/> Kidney failure
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Depression/anxiety	<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Seizures/epilepsy	<input type="checkbox"/> Acid reflux/ulcers
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Psychiatric disease	<input type="checkbox"/> Anemia
<input type="checkbox"/> Stroke	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Muscle disease
<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Asthma	<input type="checkbox"/> Lung disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Fibromyalgia		<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Cancer. Where: _____ When: _____		

Any other health problems not above: _____

Please list any surgeries you had and approximate dates: _____

Current medication name	Strength (mg)	Times per day

Over-the-counter medications you take: _____

Medication allergies: _____

What recent imaging have you had (X-Ray, CT or MRI) _____

List/describe any alternative or complementary therapies you are receiving: _____

Symptoms. Please check any symptoms you've experienced in the past 90 days.

Constitutional	GI	Musculoskeletal	<input type="checkbox"/> Language problems
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Memory loss
<input type="checkbox"/> Recurrent fevers	<input type="checkbox"/> Chronic diarrhea	<input type="checkbox"/> Back pain	<input type="checkbox"/> Passing out
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Chronic constipation	<input type="checkbox"/> Muscle cramping	<input type="checkbox"/> Poor coordination
HEENT	<input type="checkbox"/> Loss of bowel control	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Slow movements
<input type="checkbox"/> Severe headaches	<input type="checkbox"/> Nausea/vomiting	Hematologic	<input type="checkbox"/> Frequently depressed
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Can't fall asleep
<input type="checkbox"/> Double vision	Cardiorespiratory	<input type="checkbox"/> Excessive bleeding	<input type="checkbox"/> Can't stay asleep
<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Frequent infections	<input type="checkbox"/> Trouble relaxing
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Shortness of breath	Neuropsychiatric	<input type="checkbox"/> Personality changes
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Numbness of arms	<input type="checkbox"/> Nervousness/anxiety
<input type="checkbox"/> Difficulty chewing	<input type="checkbox"/> Unusual cough	<input type="checkbox"/> Numbness of legs	<input type="checkbox"/> Frequently worried
<input type="checkbox"/> Pain in jaw chewing	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Weakness of legs	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Change in speech	Endocrine	<input type="checkbox"/> Weakness of arms	<input type="checkbox"/> Loss of interest in work or home activities
<input type="checkbox"/> Head injury	<input type="checkbox"/> Fatigue easily	<input type="checkbox"/> Vertigo/spinning	
<input type="checkbox"/> Flashing lights in eyes	<input type="checkbox"/> Unusual thirst	<input type="checkbox"/> Tremors/shaking	
<input type="checkbox"/> Brief loss of vision	<input type="checkbox"/> Urinating often	<input type="checkbox"/> Difficulty walking	
GU	<input type="checkbox"/> Intolerant of cold	<input type="checkbox"/> Poor balance	
<input type="checkbox"/> Loss of bladder control	<input type="checkbox"/> Intolerant of heat	<input type="checkbox"/> Thinking impairment	
<input type="checkbox"/> Sexual difficulties	<input type="checkbox"/> Hair loss		
<input type="checkbox"/> Menstrual problems			

Yes No

Do you smoke?

Did you ever smoke? How much: _____ How long: _____

How much alcohol do you drink? _____

Family: Single Married Divorced Significant other

List ages of your children: _____

Occupation: _____

Education level: _____

Family Medical History. Explain family members who have had any of the following.

Cancer _____

Seizures _____

Stroke _____

Heart attack _____

Migraines _____

Dementia _____

Neuropathy _____

Muscle problems _____

Diabetes _____

Movement disorders _____

Psychiatric illness _____

Glaucoma _____

High blood pressure _____