

(place and X on all those that apply)

PAST PERSONAL MEDICAL HISTORY

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> H.I.V. | <input type="checkbox"/> hepatitis/ jaundice | <input type="checkbox"/> ADD / ADHD | <input type="checkbox"/> migraines / headaches |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> bladder problems | <input type="checkbox"/> thyroid disorder | <input type="checkbox"/> cancer / tumors |
| <input type="checkbox"/> asthma / wheezing | <input type="checkbox"/> heart attack | <input type="checkbox"/> heart murmur | <input type="checkbox"/> frequent urinary tract infections |
| <input type="checkbox"/> bulimia / anorexia | <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> pneumonia | <input type="checkbox"/> staphylococci infections |
| <input type="checkbox"/> epilepsy / seizures | <input type="checkbox"/> blood transfusions | <input type="checkbox"/> glaucoma | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> anemia | <input type="checkbox"/> arthritis | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> lupus |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> kidney disease | <input type="checkbox"/> kidney stones | <input type="checkbox"/> streptococci infections |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> bronchitis | <input type="checkbox"/> skin condition(s) | <input type="checkbox"/> constipation |
| <input type="checkbox"/> chronic cough | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> scarlet fever | <input type="checkbox"/> glucose intolerance |
| <input type="checkbox"/> frequent colds | <input type="checkbox"/> digestive disorders | <input type="checkbox"/> insomnia | <input type="checkbox"/> irritable bowel syndrome |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> hypoglycemia | <input type="checkbox"/> depression | <input type="checkbox"/> mumps |
| <input type="checkbox"/> Raynaud's disease | <input type="checkbox"/> palpitations | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> alcohol abuse | <input type="checkbox"/> substance abuse | <input type="checkbox"/> acid reflux | <input type="checkbox"/> sexually transmitted disease |
| <input type="checkbox"/> laxative abuse | <input type="checkbox"/> mononucleosis | <input type="checkbox"/> chicken pox | <input type="checkbox"/> genital herpes |

List any other past diseases / conditions / symptoms not mentioned above: _____

List any known allergies to foods, medicines, chemicals, animals, etc.: _____

List any significant traumas (including sexual), surgeries, auto accidents, scar locations and approximate age(s): _____

List any birth history problems (prolonged labor, forceps delivery, c-section, etc.): _____

List any previous mental health disorder(s) and diagnosis: _____

PERSONAL LIFESTYLE AND HABITS

Describe any weekly exercising and frequency: _____

Do you currently smoke? Yes No If Yes, for how long? _____ Average # of cigarettes / packs per day: _____

Do you consume alcohol? Yes No If Yes, Average # drinks per week: _____

Do you consume caffeinated beverages? Yes No If Yes, how many 8 oz. volumes per day? _____

Do you use recreational drugs? Yes No If Yes, what kind? _____ How often? _____

Do you consume a lot of sweets? Yes No If Yes, what kind? _____ How often? _____

Are you exposed to toxic chemicals / second hand smoke daily? Yes No If Yes, what type? _____

Please describe your average Breakfast: _____

daily diet and beverages and Lunch: _____

approximate time you have your meals Dinner: _____

Snacks: _____

What is the average time you go to bed? _____ What time do you wake up? _____ Do you have trouble falling asleep?

Yes No Do you have trouble staying asleep? Yes No Average number of hours you sleep? _____ Do you sleep

soundly and awaken refreshed? Yes No Describe any other sleep problems: _____

CURRENT SIGNS AND SYMPTOMS

(Check all that apply)

GENERAL

- changes in appetite
- poor appetite
- excess appetite
- bruise / bleed easily
- sweaty palms, soles and / or chest
- fatigue
- food cravings
- night sweats
- sweat easily
- difficulty sweating even when exercise
- tremors
- chill easily
- cold sweats
- peculiar taste in mouth
- fevers (or feel hot)
- sudden weight gain
- swollen glands
- sudden weight loss
- strong thirst for
 - hot
 - cold liquids
- thyroid problem

SKIN AND HAIR

- acne
- thinning hair
- dry scalp (dandruff)
- rashes
- itchy / dry skin
- skin cancer
- hives
- dermatitis
- eczema
- warts
- skin ulcers
- psoriasis
- fungal infections
- recent moles
- hair loss (alopecia)

HEAD, EYES,

EARS, NOSE,

THROAT

- glasses / contacts
- color blindness
- eye strain / pain
- night blindness
- light sensitivity
- blurred vision
- itchy, dry, red eyes

- concussion
- cataracts
- headaches
- migraines
- floaters (spots in field of vision)
- hearing loss
- ear aches
- dizziness / vertigo
- ringing in ears
- sinus congestion
- nosebleeds
- recurrent sore throats
- sore gums
- nasal congestion
- nasal discharge
 - clear
 - yellow/green
- profuse sputum
 - clear
 - yellow/green
- facial paralysis
- facial swelling
- eye swelling
- dry, itchy throat

CARDIOVASCULAR

- high blood pressure
- low blood pressure
- irregular heart beat
- chest pain / pressure
- palpitations
- heart murmur
- stroke
- rapid pulse
- slow pulse
- phlebitis
- blood clots
- cold hands or feet
- varicose veins
- edema of hands and / or feet
- dizziness when stand quickly

RESPIRATORY

- cough
- wheezing
- asthma
- bronchitis
- painful breathing
- shortness of breath
- emphysema
- coughing blood

- pneumonia
- ### GASTRO- INTESTINAL
- nausea
 - vomiting
 - indigestion
 - acid reflux
 - flatulence (gas)
 - bad breath
 - bloating after meals
 - abdominal pain
 - constipation
 - diarrhea
 - undigested food in stool
 - blood in stool
 - rectal pain
 - blackened stool
 - whitened stool
 - strong odor to stool
 - hemorrhoids
 - irritable bowel (IBS)
 - colitis
 - diverticulitis
 - Crohn's disease
 - gallbladder prob.
 - liver problem

URO-GENITAL

- urgency to urinate
- frequent urination
- unable to hold urine
- decrease in flow
- dribbling of urine
- weak urine stream
- kidney stones
- profuse urine
- sores on genitals
- blood in urine
- painful urination
- urinary tract infect.
- prostate problems

NEURO- PSYCHOLOGICAL

- seizures
- fainting
- anxiety
- depression
- memory problems
- concentration prob.
- teeth grinding
- coordination problem

- twitches or tics
- phobias
- numbness / tingling
- ADD / ADHD
- temper outbursts
- moodiness
- restless leg(s)

MALES

- painful / swollen testicles
- genital herpes
- erectile dysfunction
- low sex drive
- vasectomy
- premature ejaculation
- low sperm count
- penis pain
- penis discharge

FEMALES

- painful menses
- irregular menses
- PMS
- breast tenderness
- excess menses
- clots in menses
- endometriosis
- absence of menses
- breast lumps
- breast discharge
- vulva pain
- infertility
- genital herpes
- HPV genital warts
- uterine fibroids
- uterine cysts
- peri-menopause
- menopause
- hot flashes
- hysterectomy
- fallopian tube ligation
- low sex drive
- vaginal odor
- vaginal dryness
- twitches or tics
- vaginal itching
- vaginal discharge
- abdominal cramps
- frequent yeast infections

Patient's initials _____ (3 of 5 pages)

(Men proceed to STRESS below)

FEMALES (continued)

List any other characteristics of menses (heavy, light, spotting, clots, odor, water retention, abdominal bloating, breast tenderness. etc.):

Describe any changes in emotional state prior to / during menses: _____

Please list # pregnancies: _____ # abortions: _____ # miscarriages: _____

Are you pregnant now? Yes No If Yes, how many weeks? _____ weeks

Are you trying to get pregnant? Yes No If Yes, how long have you been trying? _____ months.

Do you practice birth control? Yes No If Yes, what type? _____

Date of last PAP: _____ / _____ / _____ Results: _____

STRESS

Rate your average, daily stress level on the 1 to 10 scale below: (1 = Minimum stress 10 = Maximum stress)

1 2 3 4 5 6 7 8 9 10

Are you currently being treated for any mental health issues? Yes No If Yes, please provide the name of your mental health professional: _____ Psychiatrist Psychologist Social Worker

Phone number: _____ --- _____ If you have a diagnosis, please state: _____

Have you recently been experiencing any thoughts of suicide? Yes No If Yes, when? _____

Are there any other current, significant relationship or stress issues that may be affecting your health? Yes No

If Yes, please explain: _____

ENERGY

On a 1 to 10 scale (10 = Max), Rate your energy level during the various times of the day listed below:

½ hr. after wake up: _____ 10:00 a.m. _____ 12:00 noon _____ 2:00 p.m. _____ 6:00 p.m. _____ 8:00 p.m. _____

(X all those that apply)

PAIN (including tingling and numbness)

- | | | | | |
|--|--|---|--|--|
| <input type="checkbox"/> headache pain | <input type="checkbox"/> shoulder pain | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> neck pain | <input type="checkbox"/> areas of numbness |
| <input type="checkbox"/> migraine pain | <input type="checkbox"/> arm pain | <input type="checkbox"/> hip pain | <input type="checkbox"/> face pain | <input type="checkbox"/> shingles |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> elbow pain | <input type="checkbox"/> leg pain | <input type="checkbox"/> eye pain | <input type="checkbox"/> genital pain |
| <input type="checkbox"/> general body pain | <input type="checkbox"/> hand pain | <input type="checkbox"/> ankle pain | <input type="checkbox"/> ear pain | <input type="checkbox"/> TMJ pain |
| <input type="checkbox"/> muscle weakness | <input type="checkbox"/> chest pain | <input type="checkbox"/> foot pain | <input type="checkbox"/> areas of tingling | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> plantar fasciitis | <input type="checkbox"/> carpal tunnel | <input type="checkbox"/> surgery pain | <input type="checkbox"/> teeth grinding | <input type="checkbox"/> tendonitis |

Describe your pain (throbbing, radiating, sharp, dull, numbness, tingling, etc.) _____

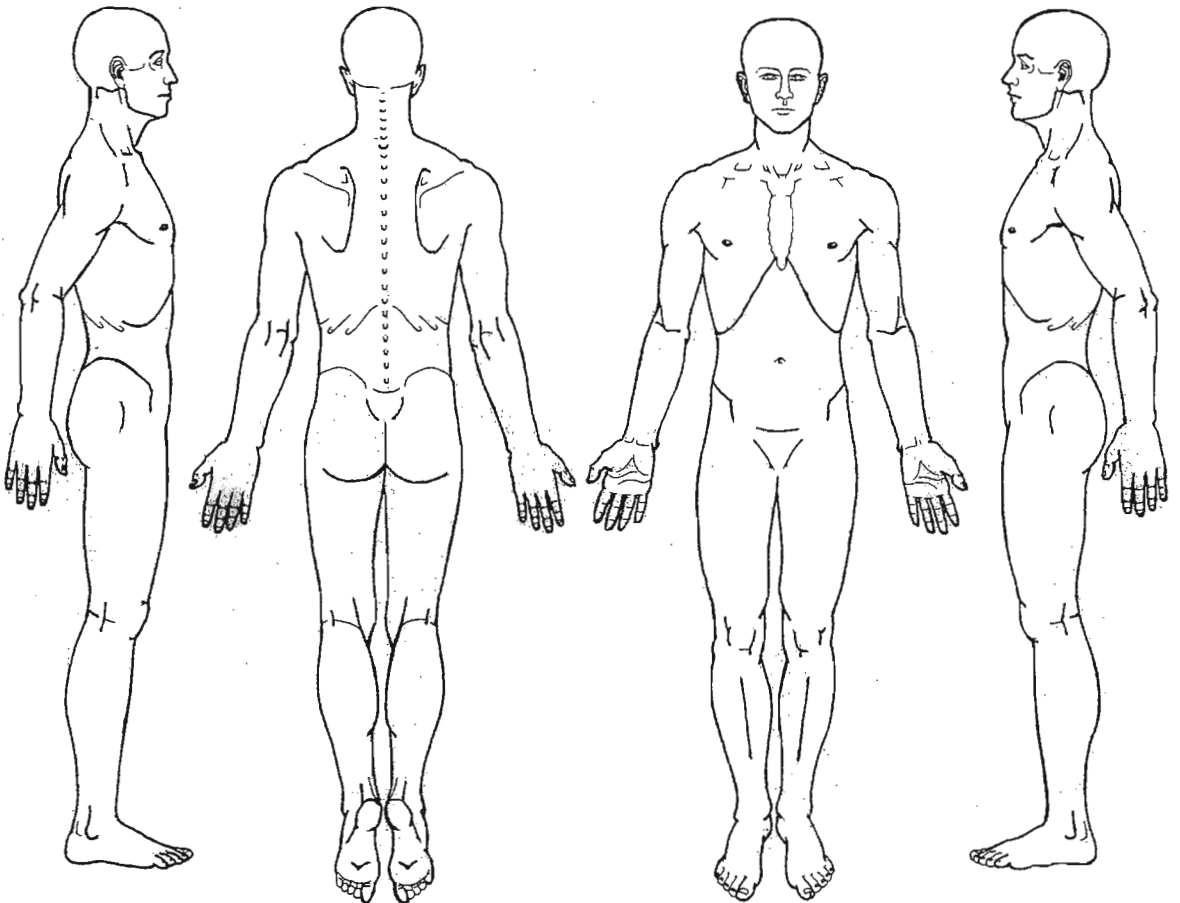
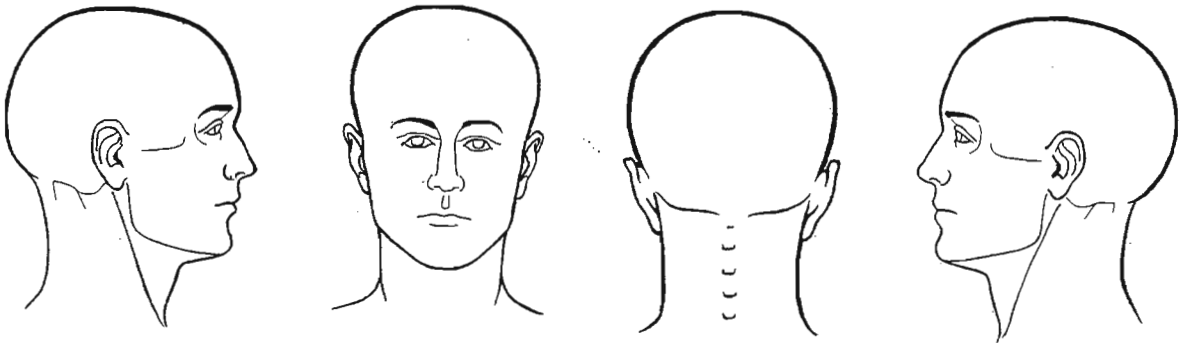
Circle a number on a 1 to 10 scale to rate your pain (10 = Maximum pain): 1 2 3 4 5 6 7 8 9 10

Does anything make the pain better? rest activity heat cold massage Other _____

Does anything make the pain worse? rest activity heat cold massage Other _____

Patient's initials _____ (4 of 5 pages)

PLEASE INDICATE THE EXACT LOCATION OF YOUR PAIN ON THE ANATOMICAL FIGURES BELOW
USE X'S TO COVER THE EXACT PAIN AREA, T'S FOR TINGLING AND N'S FOR NUMBNESS



Patient's initials _____ (5 of 5 pages)