MEDICAL HISTORY RECORD

All information is treated as confidential unless you grant permission to release it. **Please print and complete all information.**

Case No.	Medicare No.	Medicaid No.	Today's Date	Birth date	Male ☐ Female ☐
Last Name First Middle			Daytime phone	Home Phone	
Address City State Zip			Marital Status	Occupation	
Person to notify in emergency		Daytime Phone	Relationship		Last Physical Examination Date
By Doctor		Phone	Family or Referring Doctor		Phone No.
May I contact either of these Doctors for your past health records? Yes ☐ No ☐		What are your present medical symptoms?			

Family History	IF LIVING Age	IF LIVING HEALTH Good Fair Poor	IF DECEASED Death Age	IF DECEASED Death Cause
Father				
Mother				
Brothers (Circle Sisters Sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
Husband ☐ Wife ☐				
Sons (circle Daughters sex)				
1. M F				
2. M F				
3. M F				
4. M F				
5. M F				
6. M F				

Any blood relatives who have or have had any of the listed conditions

	✔	Yes	No	Relationship		✔	Yes	No	Relationship
Asthma					Hay Fever				
Arthritis					Insanity				
Allergies					Kidney Disease				
Anemia					Leukemia				
Alcoholism					Migraine				
Bleeding Tend.					Nervous Break'n				
Cancer					Obesity				
Colitis					Rheumatism				
Congenital Heart					Rheumatic Fever				
Diabetes					Stroke				
Epilepsy					Suicide				
Goiter					Stomach Ulcers				
High Bl. Press.					Tuberculosis				
Heart Disease									

HABITS

Do You	✔ Yes	No	Daily Consumption:
Smoke	☐	☐	_____ Pkgs.
Drink Coffee	☐	☐	_____ Cups
Drink Alcohol	☐	☐	_____ oz.
Drink Beer	☐	☐	_____ oz.
Fall Asleep Easily	☐	☐	
Awaken Early	☐	☐	

MEDICATIONS

✔ If Taken	✔	✔ If Taken	✔	✔ If Taken	✔
Antacids	☐	Blood Thinning Pills	☐	Iron or Poor Blood Med.	☐
Antibiotics	☐	Cortisone	☐	Laxatives	☐
Aspirin, Bufferin, Anacin	☐	Cough Medicine	☐	Phenobarbital	☐
Barbiturates	☐	Digitalis	☐	Shots	☐
Birth Control Pills	☐	Dilantin	☐	Sleeping Pills	☐
Blood Pressure Pills	☐	Hormones	☐	Thyroid Med.	☐
		Insulin, Diabetic Pills	☐	Tranquilizers	☐

✔	
Vitamins	☐
Water Pills	☐
Weight Reducing Pills	☐
Other (list)	_____
	_____
	_____
	_____

Operations you have had:	Year	Diseases you have had requiring hospitalization	Year	Serious illness not requiring hospitalization	Year

Drugs you are allergic to:

Describe any serious injuries or accidents you have had

WOMEN only:

	✔ Yes	No	
Are you still having regular monthly menstrual periods?	☐	☐	
Have you ever had bleeding between your periods?	☐	☐	When? _____
Do you have very heavy bleeding with your periods?	☐	☐	When? _____
Do you feel bloated and irritable before your period?	☐	☐	
Are you now on or have you ever taken the birth control pill?	☐	☐	When? _____
Have you ever had a miscarriage?	☐	☐	When? _____
Have you ever had a discharge from the nipple of your breast?	☐	☐	When? _____
Do you regularly have the cancer test of the cervix?	☐	☐	Date of last test _____

How many children born alive _____
How many stillbirths _____
How many premature births _____
Date of last menstrual period _____
How many miscarriages _____
How many cesarean operations _____
Any complications of pregnancy? (explain) _____

MEN only: Have you ever had:

	✔ Yes	No
Loss of sexual activity? For how long? _____	☐	☐
Treatment for genitals (private parts)?	☐	☐
Discharge from penis?	☐	☐
Hernia (rupture)?	☐	☐
Prostate trouble?	☐	☐

MEN and WOMEN:

	✔ Yes	No
Do you frequently have severe headaches	☐	☐
(If yes, answer the following):		
Do they cause visual trouble?	☐	☐
Do they occur on one side of the head?	☐	☐
Do they awaken you at night?	☐	☐
Do they feel like a tight hat band?	☐	☐
Do they hurt most in the back of the head and neck?	☐	☐
Does aspirin relieve them?	☐	☐

Have you recently had pain in the stomach which:

	✔ Yes	No
Occurs 1-2 hours after a meal?	☐	☐
Is brought on by eating fried foods, gassy foods?	☐	☐
Awakens you at night?	☐	☐
Is relieved by antacid medications?	☐	☐
Is relieved with milk or eating?	☐	☐
Occurs while eating or immediately after?	☐	☐
Is relieved by a bowel movement?	☐	☐
Causes loss of appetite?	☐	☐

	✔ Yes	No		✔ Yes	No
Have you ever fainted?	☐	☐	Have you ever had a convulsion?	☐	☐
Spells of dizziness?	☐	☐	Double vision?	☐	☐
Spells of weakness of arm or leg?	☐	☐	Pains in ear?	☐	☐
Ringing in ears?	☐	☐	Nosebleeds?	☐	☐

Do you frequently have:

	✔ Yes	No		✔ Yes	No
Bleeding gums?	☐	☐	A sore tongue?	☐	☐
Trouble swallowing?	☐	☐	Nausea and vomiting?	☐	☐
Hoarseness?	☐	☐			

Have you ever had shortness of breath?

	✔ Yes	No
Doing your usual work?	☐	☐
Climbing a flight of stairs?	☐	☐
Which awakens you at night?	☐	☐
Do you have a chronic cough?	☐	☐
Which causes you to cough?	☐	☐
Accompanied by wheezing?	☐	☐
Have you ever coughed blood?	☐	☐
Do you cough up much sputum?	☐	☐

Have you had pain or tightness in the chest which begins:

	✔ Yes	No
When exerting yourself?	☐	☐
When walking against a wind?	☐	☐
When walking up a hill?	☐	☐
After a heavy meal?	☐	☐
When upset or excited?	☐	☐
Palpitations	☐	☐
Do you sleep on more than one pillow?	☐	☐

	✔ Yes	No
Radiates down the arm?	☐	☐
Disappears if you rest?	☐	☐
Occurs only at rest?	☐	☐
When walking fast?	☐	☐
When walking in cold weather?	☐	☐

If you have chest pain or tightness please explain.....

_____

_____

Have you had?	✔ Yes	No	**When or since when?**
Burning when urinating?	☐	☐	_____
Loss of control of bladder?	☐	☐	_____
Blood in the urine?	☐	☐	_____
Dark colored urine?	☐	☐	_____
Trouble starting to urinate?	☐	☐	_____
Trouble holding the urine?	☐	☐	_____
To get up frequently at night?	☐	☐	_____
Passed a kidney stone?	☐	☐	_____

Have you recently had:	✔ Yes	No	**When or since when?**
Pains in calves of legs when walking?	☐	☐	_____
Cramps in legs at night?	☐	☐	_____
Pain in the big toe?	☐	☐	_____
Varicose veins?	☐	☐	_____
Phlebitis or inflamed leg veins?	☐	☐	_____
Swelling in the ankles	☐	☐	_____

If you have had a change in bowel habit recently answer the following:	✔ Yes	No	**When or since when?**
Crampy pain in abdomen?	☐	☐	_____
Alternating diarrhea and constipation?	☐	☐	_____
Pain during or after bowel movement?	☐	☐	_____
Mucous in the stool?	☐	☐	_____
Blood in the stool?	☐	☐	_____
Ribbon like stools?	☐	☐	_____
Black stools?	☐	☐	_____
Require use of strong laxatives or enemas?	☐	☐	_____
_____	☐	☐	_____

Describe briefly your present medical symptoms and anything else we should know about your health.

MEDICATIONS, HERBAL AND OTHER SUPPLEMENTS

PATIENTS NAME_____ DATE_____

Are you presently taking any of the following medications?

Analgesics (Aspirin, Ibuprofen, Naproxen Sodium) dosage_____frequency_____

CardiovascularAgents(Digoxin,Lanoxin,Captopril) dosage_____frequency_____

Laxatives dosage_____frequency_____

Antacids dosage_____frequency _____

Sedative, Antianxiety, Antipsychotic drugs dosage_____frequency_____

Anti Inflammatories (Prednisone, NSAIDS, Corticosteroids) dosage_____frequency_____

Respiratory Agents dosage_____frequency_____

Diuretics dosage_____frequency_____

Antibiotics dosage_____frequency_____

Elixirs containing sorbitol (Acetaminophen) dosage_____frequency_____

Insulin or Diabetic pills dosage_____frequency_____

Sleeping Pills dosage_____frequency_____

Thyroid Medication dosage_____frequency_____

Blood-thinning Pills dosage_____frequency_____

Seizure medication dosage_____frequency_____

Weight Reducing Pills dosage_____frequency_____

Birth Control (Pills, Patch, Ring, Injection) dosage_____frequency_____

Hormones dosage_____frequency_____

Blood Pressure Pills dosage_____frequency_____

Statin Drugs dosage_____frequency_____

List any other over-the-counter medications you currently use

_____

List any herbal or natural supplements, vitamins or minerals you are taking

_____

_____

Please Bring In Your Supplements and Medications to Your First Visit.

Are you allergic to any medications, natural supplements, or over-the-counter medications?
Please name them_____

1. Overall, do you generally feel more warm or cold?_____
2. Do you ever have hot flashes? Yes or No
3. Do you perspire easily? Yes or No
4. Do you perspire only with exercise or exertion or do you sweat while sitting still, or after eating?_____
5. Do you frequently get headaches? Yes or No
6. If yes, describe your headaches, location and severity on a scale of 1 to 10_____
7. Do you have any joint or other body aches?_____
8. Do you ever have shortness of breath? Yes or No
9. Do you have chest pains? Yes or No
10. Do you have heart palpitations? Yes or No
11. Do you have acid reflux, heartburn, indigestion, bloating or gas? Circle any that apply to you.
12. How is your appetite?_____
13. How much water do you drink each day?_____
14. Do you feel excessively thirsty?_____
15. How much caffeine do you drink daily?_____
16. Do you drink alcoholic beverages? Yes or No How much daily?_____
17. Do you have any difficulty with urination, such as hesitancy, burning, itching, difficulty stating or stopping the flow, dribbling, or loss of bladder control when coughing, laughing, or sneezing? Circle any that apply to you. How many times per day do you urinate?_____ How many times per night?_____
18. How many times per day do you have a bowel movement?_____ Is it difficult to pass? Circle what applies to you.....I need to sit and read.....It takes me a few minutes...I'm done in 15 seconds. Do you often have diarrhea or constipation? Yes or No
19. Describe your diet_____
20. Do you have any floaters (black spots) in your vision? Yes or No If yes, do they move around or stay in one place?_____
21. Any other vision problems such as macular degeneration or cataracts? Yes or No
22. Do you have any hearing loss or ringing in your ears?_____
23. How many hours do you sleep each night?_____
24. Do you feel rested when you wake up? Yes or No
25. Do you have any night sweats? Yes or No?
26. Do you have any reproductive issues you woul like to discuss such as infertility, PMS, menopausal symptoms, menstrual cramps, low libido, erectile dysfunction? Yes or No
27. How do you rate your overall health?_____
28. How did you hear about our clinic?_____