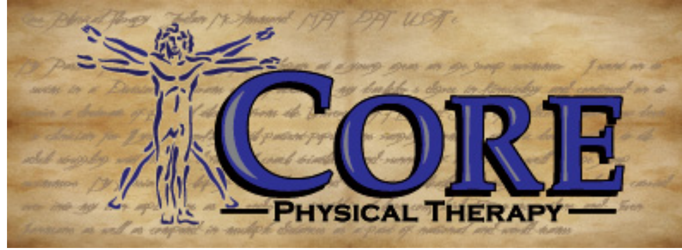

MEDICAL HISTORY FORM

Patient Name:_________________________________ **Date of Birth:**_____________

Have you or any immediate family member ever been told you have:

	Self		Family	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High Blood Pressure?	Yes	No	Yes	No
Heart Disease?	Yes	No	Yes	No
Angina/Chest Pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No

	Self		Family	
Osteoporosis?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid Arthritis?	Yes	No	Yes	No
Other___________	Yes	No	Yes	No

In the past 3 months, have you had or do you experience:

A change in YOUR health?	Yes	No
Nausea/Vomiting?	Yes	No
Fever/Chills/Sweats?	Yes	No
Unexplained Weight Change?	Yes	No
Numbness or Tingling?	Yes	No
Changes in Appetite?	Yes	No
Difficulty Swallowing?	Yes	No

Changes in Bowel/Bladder Function?	Yes	No
Shortness of Breath?	Yes	No
Dizziness?	Yes	No
Upper Respiratory Infection?	Yes	No
Urinary Tract Infection?	Yes	No
Change in your Balance? (falls?)	Yes	No

Do you have a history of:

Allergies?	Yes	No
Headaches?	Yes	No
Bronchitis?	Yes	No
Kidney Disease?	Yes	No

Rheumatic Fever?	Yes	No
Ulcers?	Yes	No
Sexually Transmitted Disease?	Yes	No
Seizures?	Yes	No

Are you currently: Pregnant Yes___No___ Depressed Yes___No___ Under Stress Yes___No___

Are your symptoms: Getting worse ___ The same ___ Improving ____

Are you able to sleep at night: Yes ____No ____ Comments: ___________________________________

Do you have a problem with hearing, vision, speech or communication? Yes ____No______

My symptoms are best in the: _________________ **My symptoms are worst in the:** ________________

Please list medications currently using: ____

Please list past surgeries including year(s): ____

Do you or have you in the past smoked? Yes ____No ____ Last tobacco use:___________________
How many packs per day?_______ **Years?** ________