MEDICAL HISTORY

Name_____ Date of Birth_____

Address_____

_____

Telephone_____
Home Work

Major Hospitalizations (start with most recent)	**Operation or Illness**
Last Hospitalization	
2nd Hospitalization	
3rd Hospitalization	

Accidents or Injury (start with most recent)	**Please Explain Nature of Accident or Injury**
Last Accident or Injury	
2nd Accident or Injury	
3rd Accident or Injury	

Additional Illnesses or Problems: Mark an X in the box next to any of the following that you have now or have ever had.

☐ eye infections	☐ pneumonia	☐ HIV	☐ scarlet fever
☐ thyroid disease	☐ pancreatitis	☐ tension/anxiety	☐ mitral valve prolapse
☐ eczema	☐ liver disease	☐ depression	☐ heart disease
☐ hives or rashes	☐ diverticulosis	☐ childhood hyperactivity	☐ polio
☐ bronchitis	☐ hernia	☐ chicken pox	☐ rheumatic fever
☐ emphysema	☐ hemorrhoids	☐ German measles	☐ malaria
☐ hepatitis	☐ blood transfusion	☐ drug abuse	☐ osteoporosis
☐ mononucleosis	☐ sexually transmitted	☐ jaundice	☐ tuberculosis
☐ cancer	disease	☐ asthma	☐ other:

Medicines: Please list any medications you are now taking and reason for taking them.

_____

_____

_____

Answer each question by checking NO or YES.	NO	YES
1. Do you have any skin problems?	☐	☐
2. Does your skin itch or burn?	☐	☐
3. Do you bruise easily?	☐	☐
4. Do you ever faint or feel faint?	☐	☐
5. Is any part of your body always numb?	☐	☐
6. Have you ever had seizures or convulsions?	☐	☐
7. Do you have a tendency to shake or tremble?	☐	☐
8. Are you very nervous?	☐	☐
9. Do you find it hard to make decisions?	☐	☐
10. Do you find it hard to concentrate or remember?	☐	☐
11. Do you usually feel depressed?	☐	☐
12. Do you often cry?	☐	☐
13. Do you have difficulty relaxing?	☐	☐
14. Do you have a tendency to worry a lot?	☐	☐
15. Are you troubled by frightening thoughts?	☐	☐
16. Do you have a tendency to be shy or sensitive?	☐	☐
17. Do you lose your temper often?	☐	☐
18. Do little things often annoy you?	☐	☐
19. Are you upset by any work or family issues?	☐	☐
20. Are you having any sexual difficulties?	☐	☐
21. Have you ever desired or sought counseling?	☐	☐
22. Do you have a tendency to be too hot or too cold?	☐	☐
23. Have you lost your interest in eating lately?	☐	☐
24. Do you always seem to be hungry?	☐	☐
25. Are you more thirsty than usual lately?	☐	☐
26. Are there any swellings in your armpits or groin?	☐	☐
27. Do you seem to feel exhausted or fatigued most of the time?	☐	☐
28. Do you have difficulty either falling asleep or staying asleep?	☐	☐
29. Do you exercise more than three times a week?	☐	☐
30. How much do you smoke in a day? _____pack		
31. Do you take two or more alcoholic drinks a day?	☐	☐
32. Do you drink more than three cups/glasses of coffee or cola per day?	☐	☐
33. Have you ever used heroin, cocaine, LSD, PCP, marijuana, etc.?	☐	☐

	NO	YES
34. Are you troubled by heartburn?	☐	☐
35. Do you feel bloated after eating?	☐	☐
36. Are you troubled by belching?	☐	☐
37. Do you suffer discomfort in the pit of your stomach?	☐	☐
38. Do you easily become nauseated?	☐	☐
39. Is it difficult or painful for you to swallow?	☐	☐
40. Are you constipated more than twice a month?	☐	☐
41. Are your bowel movements ever loose for more than one day?	☐	☐
42. Do you suffer pains when you move your bowels?	☐	☐
43. Have you had any bleeding from your rectum?	☐	☐
44. Do you frequently get up at night to urinate?	☐	☐
45. Do you urinate more than five or six times a day?	☐	☐
46. Do you ever have any accidents?	☐	☐
47. Have you ever had burning or pains when you urinate?	☐	☐
48. Do you have any difficulty starting your urine flow?	☐	☐
49. Do you have a constant feeling that you have to urinate?	☐	☐
For Men Only		
50. Is your urine stream very weak and slow?	☐	☐
51. Have you ever had prostrate trouble diagnosed?	☐	☐
52. Are there any swellings or lumps on your testicles?	☐	☐
53. Do your testicles ever get painful?	☐	☐
For Women Only		
54. Are you past your menopause, or have you had a hysterectomy?	☐	☐
55. Was your last menstrual period normal?	☐	☐
56. Do you have heavy bleeding during your periods?	☐	☐
57. Have you had bleeding between your periods?	☐	☐
58. Have you had any recent vaginal itching or discharge?	☐	☐
59. Have you ever noticed any lumps or pain in your breasts?	☐	☐
60. Have you had complications with any type of birth control?	☐	☐
61. Number of pregnancies		
62. Number of children born alive		
63. Number of premature births		
64. Number of miscarriages		
65. Number of stillbirths.		
66. Have you ever had an abortion?	☐	☐
For Both Men and Women		
67. Are you troubled with stiff or painful muscles or joints?	☐	☐
68. Are your joints ever swollen?	☐	☐
69. Are you troubled by pains in the back, neck or shoulder?	☐	☐

	NO	YES
70. Are your feet often painful?	☐	☐
71. Do you have headaches more than once a week?	☐	☐
72. Do you drive more than two hours a day?	☐	☐
73. How many hours are you at a computer each day?	_____	
74. Do you wear glasses?	☐	☐
75. Does your eyesight ever blur?	☐	☐
76. Is your eyesight getting worse?	☐	☐
77. Do you ever have pains or itching in or around your eyes?	☐	☐
78. Have you had any trouble with your eyes in the last two years?	☐	☐
79. Do you have difficulty hearing?	☐	☐
80. Do you have repeated buzzing or other noises in your ears?	☐	☐
81. Do you have any problems with your teeth?	☐	☐
82. Do you have any sore swellings on your gums or jaws?	☐	☐
83. Is your tongue sore or sensitive?	☐	☐
84. Do you have a persistent taste in your mouth?	☐	☐
85. Is your mouth frequently dry?	☐	☐
86. Is your nose stuffed up when you don't have a cold?	☐	☐
87. Does your nose run when you don't have a cold?	☐	☐
88. Do you ever have sneezing spells?	☐	☐
89. Do you ever have head colds two or more months in a row?	☐	☐
90. Do you get sinus infections frequently?	☐	☐
91. Are you ever short of breath?	☐	☐
92. Are you bothered by coughing spells?	☐	☐
93. Do you cough up a lot of phlegm?	☐	☐
94. Are you sweating more than usual or having night sweats?	☐	☐
95. Have you ever been told that you had high blood pressure?	☐	☐
96. Have you been bothered by a thumping or racing heart?	☐	☐
97. Do you ever get pains or tightness in your chest?	☐	☐
98. Do you have trouble with dizziness or lightheadedness?	☐	☐
99. Do you have trouble with swollen feet or ankles?	☐	☐
100. How much water do you drink in a day?	_____	