

Medical History Template

The purpose of this form is to understand your past and present medical history.

Primary Complaint

Aggravating and Relieving Factors

Secondary Complaint

Aggravating & Relieving Factors

Other Complaints

Your Past Medical History (please add the year diagnosed next to subject)

Please Mark The Check Box If You Previously Suffered From These Conditions.

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Bird Flu |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Diabetes Type 2 |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Hypertension | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Hyper Thyroid | <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Hypo Thyroid | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mono | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Mumps | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Polio | <input type="checkbox"/> PTSD | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Reynaud's Disease |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> STD's | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Uterine Fibroids |

Auto-immune Disorders? Type? Year Diagnosed? Treatments received. Cancer? What Type? Year Diagnosed? Treatments received.

Hospitalization, Operations and Significant Traumas

Your Family's Medical History

Addictions

Asthma

Cancer

Diabetes

Fatty Liver

High Blood Pressure

Heart Disease

Mental Disease

Strokes

Thyroid Disease

Tell Us About Your Lifestyle

Diet

Exercise

Mark The Ones That Describe You

- Sleep After Midnight Drink Coffee Often Drink Soda Often
 Smoke Tobacco Daily Smoke Marijuana Often Drink Alcohol Often

Recreational Drugs? Past Addictions?

Stress Level

Current State of Health (please add an est. date the symptoms began next to the subject)

My Body Temperature Feels?

- Hot Cold Normal

General Symptoms

- Edema Bruise Easy Chills
 Fever Body Aches Aversion To Wind
 Aversion To Cold Aversion To Heat Strong Thirst
 Low Thirst Poor Appetite Night Sweats
 Insomnia Fatigue Nasal Congestion
 Foggy Headed Dizziness Short Of Breath

Head, Eyes, Ears, Nose & Throat Symptoms

- Dry Eyes Red Eyes Blurry Vision
 Poor Night Vision Floaters Eye Strain
 Difficult to Focus Cataracts Glasses/Contacts
 Ear Ringing: High Pitch Ear Ringing: Low Pitch Poor Hearing
 Block Sinus Grinding Teeth Dental Problems
 Hoarse Voice Headaches Concussion
 Mouth Sores/Ulcers Migraines Nose Bleeds
 TMJ Facial Pain Ear Aches
 Sore Throat Plum Pit Feeling in Throat Excess Saliva

Cardiovascular Symptoms, Signs & Diseases

- High Blood Pressure Low Blood Pressure Irregular Heart Beat

- Heart Beating Fast
- Swelling of Hand/Feet
- Fainting

- Heart Palpitations
- Phlebitis
- Left Arm Pain

- Cold Hand/Feet
- Chest Pain
- Varicose Veins

Respiratory Signs & Symptoms

- Dry Cough
- Phlegmy
- Pain When Breathing Deep
- Post Nasal Drip

- Wet Cough
- Pneumonia
- Short of Breath
- Labored Breathing

- Bronchitis
- Asthma
- Chest Tightness
- Breath Feels Hot

GastroIntestinal

- Nausea
- Gas
- Hiccup
- Indigestion
- Anal Fissures

- Constipation
- Bloating
- Acid Regurgitation
- Bad Breath
- Itchy Anus

- Diarrhea
- Abdominal Pain/Cramp
- Belching
- Rectal Pain
- Hemorrhoids

Genitourinary

- Frequent Urination
- Incomplete Urination
- Unable to Hold Urine
- Smelly Urine
- Wet Dreams
- Low Semen Volume (Men)
- Genital Sores

- Wakes Up To Urinate
- Decrease Flow
- Bedwetting
- Dark Yellow Urine
- Impotence (Men)
- Premature Ejaculation
- High Libido

- Pain During Urination
- Decrease Stream Power
- Urinary Tract Infection
- Kidney Stones
- Enlarged Prostate (Men)
- Genital Itching
- Low Libido

Gynecological & Obstetrics (Women Only)

- Currently Pregnant
- No Menstrual Cycle
- PCOS
- Uterine Fibroids

- Irregular Menses
- Endometriosis
- PMS
- Vaginal Sores

- Menstrual Clots
- Ovarian Cysts
- PID
- Frequent Yeast Infections

Gynecological

Last Menstrual Period

Date of Last PAP

Age Menses Started

Number of Days Between Periods?

How Many Days Do You Bleed (During Period)?

Menstrual Blood Clots

Color of Menstrual Blood

What is Your Flow Like?

Irregular Menses

Mid-Cycle Bleeding?

Menopause. Year and age of onset.

Birth Control

Breast Lumps

Vaginal Discharge

Obstetrics

How many months pregnant?

Previous Live Births?

Premature Births?

Any Miscarriages?

Previous Abortions?

IVF? How many attempts or cycles completed.

Musculoskeletal (please add an est. date the symptoms began- next to the subject)

What Areas Are Painful?

Head

Neck

Shoulder

Upper Back

Middle Back

Lower Back

Ribs

Wrist

Hip

Upper Leg

Side of Leg

Lower Leg

Knee

Ankle

Foot

Fingers

Toes

Groin

General Muscle Weakness

Muscle Tightness

Full Body Aches/Pain

Neuropsychological (please add an est. date the symptoms began- next to the subject)

Do You Feel Numbness?

Face

Shoulder

Arms

Wrists

Fingers

Toes

Legs

Ankles

Foot

Frequent Emotions

Fear

Grief

Worried

Depression

Anxiety

Anger

Suicidal

Irritable

Manic

General Symptoms

Dizziness

Loss of Balance

Lack of Coordination

Memory Loss

Tremors

Panic Attacks

Paralysis

Other Neurological Issues

Anything We Missed or You Want To Tell Us?