Medical History Form

Date _____ Time of Birth _____

Name _____ Age _____ Date of Birth _____ Sex _____

Address _____ City _____

State _____ Zip _____ Phone (home) _____

Work Phone _____ Cell Phone _____

Occupation _____ Education _____

Full Time ☐ Part time ☐ Unemployed ☐ Retired ☐ Disabled ☐

Members of Household	Age/Date of birth	Relationship

What are your most important health care problems? Please list in order of importance

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

Have you had any of the following medical conditions? (check all that apply)

Now	Past		Now	Past	
☐	☐	AIDS	☐	☐	Bleeding
☐	☐	Alcohol Abuse	☐	☐	Cancer
☐	☐	Allergies	☐	☐	Colitis
☐	☐	Anemia	☐	☐	Cohn's Disease
☐	☐	Anorexia	☐	☐	Depression
☐	☐	Arthritis	☐	☐	Diabetes
☐	☐	Asthma	☐	☐	Diarrhea
☐	☐	Bulimia	☐	☐	Drug Abuse
☐	☐	Dysentery	☐	☐	Meningitis
☐	☐	Easy Bruising	☐	☐	Mental illness
☐	☐	Eczema	☐	☐	Migraines/Headaches
☐	☐	Emphysema	☐	☐	Nervous breakdown
☐	☐	Epilepsy/Seizures	☐	☐	Obesity
☐	☐	Food Poisoning	☐	☐	Pneumonia
☐	☐	Gallstones	☐	☐	Polio
☐	☐	Gout	☐	☐	Psoriasis
☐	☐	Gum/Tooth Disease	☐	☐	Stroke
☐	☐	Hypertension	☐	☐	Syphilis
☐	☐	Infections, Chronic	☐	☐	Thyroid problems
☐	☐	Kidney Disease	☐	☐	Tuberculosis
☐	☐	Liver disease	☐	☐	Tumors
☐	☐	Lung disease	☐	☐	Typhoid
☐	☐	Malaria	☐	☐	Ulcers
☐	☐	Malnutrition	☐	☐	Worms

Trauma History List any abuse, major accidents, head injuries, falls, blows, etc.

_____

Any loss of consciousness? Yes ☐ No ☐ Please describe: _____

Hospitalizations

Illnesses/ Inpatient or outpatient surgery **Date**

Any history of animal bites? _____

List of current prescription medications: _____

_____

Any history of allergic reactions to medications? _____

List of any current or previous homeopathic remedies: _____

List of current vitamins and supplements: _____

List of any other current medical or health treatments (e.g. acupuncture, massage, dental)

_____

Check any of the following that you use. How much of each for how long?

coffee	☐	☐	Marijuana	☐	sleeping pills
tea	☐	☐	recreational drugs	☐	thyroid replacement
cigarettes/cigars	☐	☐	aspirin	☐	hormone replacement
snuff/chewing tobacco	☐	☐	Tylenol	☐	birth control pills
alcohol	☐	☐	ibuprofen	☐	Chinese herbs
soft drinks	☐	☐	laxatives	☐	herbs

Do you use an electric blanket? ☐ Yes ☐ No

Do you get regular exercise? ☐ Yes ☐ No Is so, what kind? _____

Any special diet? _____

FAMILY HISTORY

Relation	Living	Dead	Age	major illness/ cause of death
Mother	☐	☐		
Father	☐	☐		
Brother(s)	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
Sister(s)	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
Maternal grandmother	☐	☐		
Maternal grandfather	☐	☐		
Paternal grandmother	☐	☐		
Paternal grandfather	☐	☐		

Please check any of the following that have occurred in your blood relatives

heart disease	☐	stroke	☐	neurological disorder	☐
kidney disease	☐	glaucoma	☐	suicide	☐
seizures/epilepsy	☐	mental illness	☐	depression	☐
hypertension	☐	cancer	☐	alcoholism	☐
thyroid disease	☐	tuberculosis	☐	drug abuse	☐
diabetes	☐	sexually transmitted disease (e.g. syphilis, gonorrhea, AIDS)			

Birth and development history

Did your mother have any problems during pregnancy?
Problems during labor and delivery?
Was there any delay in your walking or talking?
was there any prolonged bed-wetting?

Childhood illnesses (please check all you have had)

rubella ☐	measles ☐	whooping cough ☐	scarlet fever ☐
rheumatic fever ☐	mumps ☐	chickenpox ☐	polio ☐

Immunization history (please check all you have had)

DPT ☐	smallpox ☐	pneumovax ☐	Polio ☐
measles/mumps /rubella ☐	TB ☐	hepatitis ☐	Flu ☐

Did you have any bad reactions or chronic illnesses following immunizations? Yes ☐ No ☐

If so, what?

Please list your hobbies and interests:_____

Favorite books: _____

Favorite movies: _____

Mental symptoms (check any symptoms that are strong, chronic or feel significant to you)

Now	Past		Now	Past	
☐	☐	absent minded	☐	☐	lazy
☐	☐	angered easily	☐	☐	lonely
☐	☐	annoyed by little things	☐	☐	memory problems
☐	☐	anxiety	☐	☐	mental mistakes (dyslexia, etc.)
☐	☐	competitive	☐	☐	mood swings
☐	☐	concentration difficulties	☐	☐	nail biting
☐	☐	consolation desired	☐	☐	nervousness
☐	☐	consolation not wanted	☐	☐	nightmares
☐	☐	critical	☐	☐	obstinate
☐	☐	depression/ prolonged sadness	☐	☐	obsessive thinking
☐	☐	dwelling on past	☐	☐	relaxation difficulties
☐	☐	euphoria	☐	☐	restlessness
☐	☐	hallucinations	☐	☐	revengeful
☐	☐	hearing voices	☐	☐	shy/timid
☐	☐	hopeless outlook	☐	☐	sloppy/ messy
☐	☐	hurried/ hyperactive	☐	☐	startle easily
☐	☐	impatient	☐	☐	suspicious
☐	☐	increased irritability	☐	☐	temper
☐	☐	indecisive	☐	☐	tidy/fastidious
☐	☐	indifferent/ apathetic	☐	☐	weep easily/frequently
☐	☐	insomnia	☐	☐	worry, excessive
☐	☐	jealousy			

Fears (Please check any significant)

☐ accidents	☐ devil	☐ hurting others	☐ rejection
☐ appearing in public	☐ disease	☐ injury	☐ robbers
☐ being alone	☐ dogs	☐ insects	☐ snakes
☐ birds	☐ failure	☐ insanity	☐ spiders
☐ blood	☐ fainting	☐ knives	☐ storms
☐ bridges	☐ flying	☐ mice	☐ strangers
☐ cancer	☐ future	☐ monsters	☐ sudden noises
☐ cats	☐ ghosts	☐ narrow places	☐ suffocation
☐ crowds	☐ health of family	☐ opposite sex	☐ thunderstorms
☐ dark	☐ heart disease	☐ people	☐ tunnels
☐ death	☐ heights	☐ poverty	☐ of unknown
☐ deep water		☐ public speaking	☐ violence

Please list any other fears you may have: _____

Are there experiences in your life that have had a lasting effect or from which you have never recovered?

_____

General symptoms: How do you react to the following conditions? (check all that apply)

	Not affected by	Worse from	Dislike	Better from	Like / prefer
humidity	☐	☐	☐	☐	☐
wind	☐	☐	☐	☐	☐
draft	☐	☐	☐	☐	☐
heat	☐	☐	☐	☐	☐
cold	☐	☐	☐	☐	☐
rain	☐	☐	☐	☐	☐
fog	☐	☐	☐	☐	☐
sun	☐	☐	☐	☐	☐
change in temperature	☐	☐	☐	☐	☐
change of season	☐	☐	☐	☐	☐
summer	☐	☐	☐	☐	☐
winter	☐	☐	☐	☐	☐
spring	☐	☐	☐	☐	☐
autumn	☐	☐	☐	☐	☐
sleep	☐	☐	☐	☐	☐
afternoon nap	☐	☐	☐	☐	☐
lying down	☐	☐	☐	☐	☐
sitting	☐	☐	☐	☐	☐
standing	☐	☐	☐	☐	☐
running	☐	☐	☐	☐	☐
climbing stairs/hills	☐	☐	☐	☐	☐
exercise in general	☐	☐	☐	☐	☐
eating	☐	☐	☐	☐	☐
talking	☐	☐	☐	☐	☐
touch	☐	☐	☐	☐	☐
tight cloths	☐	☐	☐	☐	☐
warm bath/shower	☐	☐	☐	☐	☐
cold bath/shower	☐	☐	☐	☐	☐
full moon	☐	☐	☐	☐	☐
being near or in ocean	☐	☐	☐	☐	☐
being in the mountains	☐	☐	☐	☐	☐

Music - What Types? _____

Strongly sensitive to: (please check all that apply)

noise	☐	pollen	☐
dust/mold	☐	odors in general	☐
getting feet wet	☐	cigarette smoke	☐
exhaust	☐	other (please specify): _____	
perfume	☐		

Have you had:

Now	Past	
☐	☐	large weight gains
☐	☐	large weight losses
☐	☐	chronic fatigue
☐	☐	weakness

Do you have a dip in energy at regular times every day or night? Yes ☐ No ☐

If so, when? _____

What time of day do you have your best energy? _____

Do you have any periodic symptoms that come at regular intervals? Yes ☐ No ☐

If so, what ate they? _____

Sleep

Now	Past	
☐	☐	Difficulty falling asleep
☐	☐	jerking, on falling asleep
☐	☐	interrupted sleep
☐	☐	sleep walking
☐	☐	talking in sleep
☐	☐	grinding teeth in sleep

Favorite sleep positions(s) _____

Staycovered during the night? _____

Stick feet out from covers? _____

Wear socks to bed? _____

Feeling on waking in the morning _____

Feeling on waking from nap _____

Dreams (please check any dreams you have had)

animals	☐	desert	☐	missing train	☐	poison	☐	praying	☐
cats	☐	ocean	☐	unprepared	☐	intrigue	☐	religious	☐
dogs	☐	river	☐	grief	☐	talking	☐	spiritual	☐
horses	☐	snow	☐	weeping	☐	singing	☐	god	☐
insects	☐	death	☐	vexation	☐	dancing	☐	house of worship	☐
wild animals	☐	dead bodies	☐	quarrels	☐	business	☐	remote events	☐
worms	☐	body parts	☐	jealousy	☐	money	☐	recent events	☐
snakes	☐	suicide	☐	insults	☐	day's work	☐	future events	☐
robbers	☐	hunger	☐	misfortunes	☐	physical work	☐	prophetic	☐
thieves	☐	thirst	☐	insecurity	☐	vomiting	☐	children	☐
ghosts	☐	eating	☐	danger	☐	passing stool	☐	parties	☐
traveling	☐	drinking	☐	pursuit	☐	urinating	☐	birth	☐
flying swimming	☐	foods	☐	accidents	☐	bleeding	☐	wedding	☐
riding/driving	☐	fruit	☐	falling	☐	pain	☐	funerals	☐
drowning	☐	fire	☐	shooting	☐	illness	☐	the dead	☐
houses	☐	lightening	☐	rape	☐	sickness	☐	fatigue	☐
buildings	☐	storms	☐	wars	☐	mutilation	☐	fearful	☐
bridges	☐	rain	☐	police	☐	romantic	☐	anxious	☐
trees	☐	failure	☐	imprisonment	☐	erotic	☐	happy	☐
mountains	☐	exams	☐	cries	☐	sexual pleasure	☐	ecstatic	☐
		failing effort	☐	murder	☐	nakedness	☐		

Have you had any recurring dreams? If so, please describe

_____

Please elaborate on any dreams that have made a strong impression on you:

_____

_____

Perspiration

Now	Past	
☐	☐	excessive sweating; specify part of body
☐	☐	strong odor of perspiration
☐	☐	night sweats

Head symptoms

Now	Past	
☐	☐	hair loss
☐	☐	dandruff
☐	☐	heaviness
☐	☐	constriction
☐	☐	headaches, location:
☐	☐	sensitive scalp
☐	☐	eruptions
☐	☐	aversion to hats
☐	☐	marked sweating, location:

Vertigo

Now	Past	
☐	☐	loss of balance
☐	☐	fainting spells
☐	☐	dizziness
☐	☐	discomfort with heights
☐	☐	car/sea/motion sickness

Eye symptoms

Now	Past	
☐	☐	poor eyesight
☐	☐	blindness
☐	☐	aversion to sun
☐	☐	double vision
☐	☐	eye infections
☐	☐	itchy eyes
☐	☐	sensation of sand in eyes
☐	☐	sties
☐	☐	see halos, spots or lights
☐	☐	pain in eyes
☐	☐	excessive tearing
☐	☐	redness

Ear symptoms

Now	Past	
☐	☐	discharge from ears
☐	☐	pain in ears
☐	☐	chronic ear infections
☐	☐	ringing /noises in ears
☐	☐	hearing loss
☐	☐	itching in ears

Nose symptoms

Now	Past	
☐	☐	nose bleeds
☐	☐	loss of smell
☐	☐	congestion
☐	☐	sinus infections
☐	☐	breathing problems Day Night
☐	☐	frequent sneezing
☐	☐	eruptions/sores

Facial symptoms

Now	Past	
☐	☐	pain/neuralgia
☐	☐	acne
☐	☐	twitching
☐	☐	excessive sweating
☐	☐	discoloration Which color?

Mouth/Teeth symptoms

Now	Past	
☐	☐	gum infections
☐	☐	bleeding gums
☐	☐	fever blisters
☐	☐	bad breath
☐	☐	caner sores
☐	☐	many dental cavities
☐	☐	tooth sensitivity
☐	☐	TMJ pain
☐	☐	cracked lips
☐	☐	cracking jaw
☐	☐	peculiar taste, please describe:
☐	☐	cracks on tongue
☐	☐	excessive salivation Day Night

Digestive symptoms

Now	Past	
☐	☐	heartburn
☐	☐	indigestion
☐	☐	frequent nausea
☐	☐	recurrent vomiting
☐	☐	diarrhea
☐	☐	constipation
☐	☐	bloody stool
☐	☐	light colored stool
☐	☐	rectal pain
☐	☐	rectal itching
☐	☐	worse from missing a meal
☐	☐	bloating
☐	☐	belching
☐	☐	flatulence/passing gas
☐	☐	marked thirst
☐	☐	thirst less
☐	☐	appetite increased
☐	☐	appetite decreased
☐	☐	hurried eating
☐	☐	loss of taste
☐	☐	difficulty swallowing
☐	☐	abdominal or stomach pain

Do you have a strong desire for any particular food? _____

Do you strongly dislike any particular food? _____

Are there any foods which make you feel bad or aggravate any of your symptoms? _____

_____

Urogenital symptoms

Now	Past	
☐	☐	frequent urination
☐	☐	painful urination
☐	☐	difficult urination
☐	☐	involuntary urination
☐	☐	strong smelling urine
☐	☐	blood in urine
☐	☐	frequent masturbation
☐	☐	change in sexual energy Please specify: _____

Male symptoms

Now	Past	
☐	☐	difficult or loss of erection
☐	☐	painful erections
☐	☐	discharges
☐	☐	lumps or swelling in the testicles
☐	☐	infertility

Female symptoms

Now	Past	
☐	☐	vaginal infections/discharge
☐	☐	vaginal itching
☐	☐	cervical problems
☐	☐	irregular periods
☐	☐	bleeding between menstrual periods
☐	☐	infertility
☐	☐	PMS
☐	☐	excessive menstrual flow
☐	☐	vaginal dryness
☐	☐	few or no orgasms
☐	☐	pain in breasts
☐	☐	swelling or lumps in breasts
☐	☐	discharge form breasts

When did you begin menstruating? _____

How long do your periods usually last? _____

Number of pregnancies: _____ Number if births: _____ Caesareans: _____

Miscarriages: _____ Abortions: _____

Any complications during pregnancy? Yes ☐ No ☐ If so, what? _____

Did you breastfeed your children? Yes ☐ No ☐ If so, how long? _____

Respiratory symptoms

Now	Past	
☐	☐	Persistent/recurrent hoarseness
☐	☐	loss of voice
☐	☐	persistent throat pain
☐	☐	chronic throat infections
☐	☐	swollen tonsils
☐	☐	frequent chest colds
☐	☐	wheezing
☐	☐	persistent cough
☐	☐	coughing up mucus
☐	☐	coughing up blood
☐	☐	pain on breathing
☐	☐	difficulty breathing when walking
☐	☐	difficulty when climbing stairs
☐	☐	difficulty when lying

Cardiovascular symptoms

Now	Past	
☐	☐	palpitations
☐	☐	chest pain at rest
☐	☐	chest pain with walking/exertion
☐	☐	ankle or leg swelling
☐	☐	leg pain unrelated to injury
☐	☐	easy bruising or bleeding, from where?

Skin symptoms

Now	Past	
☐	☐	rough skin, dry skin
☐	☐	itching
☐	☐	rashes
☐	☐	moles
☐	☐	nail changes
☐	☐	shingles/herpes
☐	☐	pimples
☐	☐	boils
☐	☐	warts
☐	☐	cysts
☐	☐	infections
☐	☐	hives or urinary
☐	☐	swollen glands, location?
☐	☐	eczema, location?
☐	☐	pustules
☐	☐	discoloration, what color?
☐	☐	easy bruising
☐	☐	skin cracks, location?

Musculoskeletal symptoms

	Now	Past	Location
pain	☐	☐	☐
stiffness	☐	☐	☐
swelling	☐	☐	☐
numbness	☐	☐	☐
tightness	☐	☐	☐
burning/heat	☐	☐	☐
coldness	☐	☐	☐
twitching	☐	☐	☐
tremors	☐	☐	☐
weakness	☐	☐	☐
paralysis	☐	☐	☐

Please list any symptoms not covered in the sections above, or add any information to help:

Clarify your history: _____