Patient's Legal Name:

____ Date of Birth ______________
Last First Middle

PERSONAL HEALTH HISTORY

What is the main reason for your visit to our clinic today? ________________________________

____

When did you last visit a doctor's office, medical clinic, or hospital? Please explain. ______________

____

Are you aware of any allergies to food, drugs, or other environmental allergens (cats, mold, dust)? If yes, please list and explain: ________________________________

____

What hospitalizations or surgeries have you had? ________________________________

____

Have you ever been diagnosed with a chronic medical condition (heart disease, diabetes, cancer, etc)?

____

Medications and/or Supplements

Do you take or use any of the following?

☐ Pain relievers (aspirin, ibuprofen)	☐ Antacids	☐ Diet pills, appetite suppressants
☐ Cortisone (cream or pills)	☐ Laxatives	☐ Tranquilizers
☐ Thyroid medication	☐ Antibiotics	☐ Sleeping pills

Please list any prescription medications, over-the-counter medications, vitamins, or other supplements you are taking:

____

____

____

General

Height: ______________ Weight: ____________lbs. Weight one year ago: __________lbs.
Maximum weight: ______________lbs. When? ________________________
When during the day is your energy best? ______________ Worst? ______________

Is there anything else you would like us know in order to serve you better?

____

____

____

Review of Systems

Please circle. Y= Yes, present condition. N=No, never had the condition. P=Problem of the past.

General

Dizziness Y P N Night sweats Y P N Fatigue Y P N

Head

Headaches Y P N Migraine headaches Y P N Jaw/TMJ problems Y P N

Skin

Rashes Y P N Eczema, hives Y P N Color changes Y P N

Musculoskeletal

Joint pain Y P N Muscle spasms Y P N Weakness Y P N

Neurological

Fainting Y P N Numbness/tingling Y P N Muscle weakness Y P N
Seizures Y P N Paralysis Y P N Loss of memory Y P N

Emotional

Mood swings Y P N Nervousness Y P N Tension/stressed Y P N
Anxiety Y P N Depression Y P N

Endocrine

Excessive thirst Y P N Cold intolerance Y P N Thyroid problems___________________
Excessive hunger Y P N Heat intolerance Y P N Diabetes ___________________________

Respiratory/Cardiovascular

Cough Y P N Shortness of breath Y P N Shortness of breath lying down Y P N
Asthma Y P N Chest pain Y P N Abdominal pain Y P N
Blood clots Y P N Heart disease Y P N Low/high blood pressure Y P N

Gastrointestinal

Diarrhea Y P N Constipation Y P N Abdominal pain Y P N
Blood in stool Y P N Nausea/Vomiting Y P N
How many bowel movements per day? ___________

Urinary

Incontinence Y P N Frequent infections Y P N Painful urination Y P N

Male Reproductive

Hernias Y P N Testicular masses Y P N Sexual difficulty Y P N

Female Reproductive

Age of first menses ____________ Age of last menses (if menopausal) _______ Length of cycle ___________
Duration of menses ____________ Date of last annual exam ____________ Number of pregnancies _______
Number of live births __________ Number of miscarriages _____________ Number of abortions __________
Birth control Y P N If yes, what type?____