

CONFIDENTIAL MEDICAL HISTORY

This information is essential in helping to make an accurate diagnosis and provide you with the most effective treatment possible. Please fill out this form completely and as accurately as you can. Attach a separate page or use the back of this form if needed.

Name: \_\_\_\_\_ Date \_\_\_\_\_

Birth date: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood pressure \_\_\_\_\_ Date of last physical \_\_\_\_\_

Describe your main complaint: \_\_\_\_\_  
\_\_\_\_\_

What has been diagnosed? (by a physician): \_\_\_\_\_  
\_\_\_\_\_

Are you currently being treated by a physician? Yes \_\_\_ No \_\_\_ If yes, for what? \_\_\_\_\_  
\_\_\_\_\_

Any problems/ complications with your birth? Please circle: Premature overdue c-section prolonged labor jaundice other (please specify): \_\_\_\_\_

**Vaccination History:** Any negative reactions that you remember? \_\_\_\_\_  
\_\_\_\_\_ Any unusual vaccinations? \_\_\_\_\_

**Surgeries & Injuries:** List any surgeries (even minor surgeries) or injuries. Please only list major injuries or ones that have had a lasting impact. (use the back of this form if necessary):

**Childhood**

Age: \_\_\_\_\_ Surgery or injury: \_\_\_\_\_

Age: \_\_\_\_\_ Surgery or injury: \_\_\_\_\_

Age: \_\_\_\_\_ Surgery or injury: \_\_\_\_\_

**Adolescence**

Age: \_\_\_\_\_ Surgery or injury: \_\_\_\_\_

Age: \_\_\_\_\_ Surgery or injury: \_\_\_\_\_

Age: \_\_\_\_\_ Surgery or injury: \_\_\_\_\_

**Adulthood**

Age: \_\_\_\_\_ Surgery or injury: \_\_\_\_\_

Age: \_\_\_\_\_ Surgery or injury: \_\_\_\_\_

Age: \_\_\_\_\_ Surgery or injury: \_\_\_\_\_

Age: \_\_\_\_\_ Surgery or injury: \_\_\_\_\_

Do you have any scars (even minor ones) from any of the above? Please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_ Date \_\_\_\_\_

**Please place a check by any of the following that are part of your medical history:**

- pregnancy (# \_\_\_\_\_ )     pace maker     HIV+     hepatitis (type \_\_\_\_\_ )
- herpes (type \_\_\_\_\_ )     bruise easily     seizures     cancer (type \_\_\_\_\_ )

**Family History**

Has any member of your immediate family had any of these conditions? (place letter by all that apply)

- |                                       |                            |
|---------------------------------------|----------------------------|
| a. asthma                             | mother _____               |
| b. cancer                             | father _____               |
| c. diabetes                           | brother _____              |
| d. seizures                           | sister _____               |
| e. heart disease                      | maternal grandmother _____ |
| f. high blood pressure                | maternal grandfather _____ |
| g. stroke                             | paternal grandmother _____ |
| h. alcoholism                         | paternal grandfather _____ |
| i. high cholesterol                   | aunt _____                 |
| j. neurological disorders             | uncle _____                |
| k. psychological disorders            |                            |
| l. orthopedic disorders               |                            |
| m. food allergies (dairy, wheat, etc) |                            |
| n. thyroid disease                    |                            |
| o. other (please specify):            | _____                      |

**Medications/ Supplements/ Herbs/ Vitamins/ Minerals**

Please list any medications, supplements, herbs, vitamins or minerals you are currently taking:

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Is there anything else that is significant in your health history? \_\_\_\_\_

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

## SYMPTOM/ CONDITION LIST

**Circle** any problem, symptom or disease that *bothers you now*. **Underline** anything that *bothered you in the past, (regardless of how long ago it was)*. Please be as accurate as possible.

**Skin:** eczema acne skin rashes dermatitis furuncles fungal infections warts psoriasis

**Heart and vascular:** fast pulse (over 100 beats/ min.) slow pulse (under 60 beats/ min.) palpitation irregular pulse feeling of pressure in your chest shortness of breath chest pain pericarditis dizziness migraine headache with nausea cold hands/ cold feet Raynaud's disease flushed face anemia high or low blood pressure cold sweats red face varicose veins stroke deep vein thrombosis feel dizzy or faint when standing up quickly or standing for a long time

**Gastrointestinal:** constipation diarrhea no appetite stomach pain indigestion heartburn gas belching ulcer gastritis lack of stomach acid hemorrhoids ileocecal valve spasm peritonitis pancreatitis appendicitis irritable bowel polyps GI tumors food allergy/ sensitivity

**Respiratory:** asthma bronchitis emphysema chronic cough wheezing pneumonia lung abscess environmental allergies (pollen, dander, grass, etc)

**Hormone Imbalance:** low thyroid over active thyroid diabetes hypoglycemia

other hormone imbalances: \_\_\_\_\_

**Male:** impotency premature ejaculation prostate gland problem vasectomy infertility low libido incomplete urination/ dribbling undescended testicle(s)

**Female:** heavy/ light/ irregular periods cramping PMS emotional reactions cysts fibroids endometriosis miscarriage menopause symptoms tubal ligation infertility low libido frequent bladder infections

**Neurological:** tremors ticks twitching Bell's Palsy paralysis numbness tingling burning pain

**Autoimmune & inflammatory conditions:** Hashimoto's disease (thyroid) rheumatism colitis systemic lupus erythematosus Crohn's disease alopecia (baldness) cellulitis atopic dermatitis neurodermatitis vulvitis low immunity

**Effects of focal infections:** rheumatic disease rheumatic fever skin disease streptococci infections staphylococci infections

**Connective tissue:** arthritis myofascial pain syndrome fibromyalgia tendonitis plantar fasciitis

**Ear nose & throat:** deafness tinnitus (ringing in the ear) itchy ear ear pain ear infections sore throat sinus headaches yellow mucus stuff nose post nasal drip dry throat itchy throat swollen glands constant sinus congestion streptococci throat infections easily catch colds

**Oral disease:** bleeding gums periodontitis dental abscess mumps toothaches without cavities TMJ stomatitis (inflammation of the mouth) loose teeth

**Other:** insomnia exhaustion psychosomatic disorder constant slight fever kidney stones emotional problems (angry, irritable, depressed, anxious, etc.) difficult concentrating on a task car/ sea/ air sickness no appetite for breakfast moody in morning easily jet lagged never sweat unusual sweating (palms, soles, elsewhere) trouble adjusting to temperature change gall stones

**Before noon time:** no energy feel spacey scattered mind long shower or bath makes you feel dizzy energetic all evening, but hate to wake up early in the morning

**Medication and Drugs:** Birth control tobacco caffeine alcohol marijuana stimulants

**Not listed above:** \_\_\_\_\_