PATIENT HISTORY

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Patient Name: ____________________ DOB:__________ Age: _____ Gender: M F

T Heart Rate_ _ Blood Pressure________ Respiration__________ Height_____ Weight__

Allergies____

Medical Background

What is your chief complaint?____

Describe more fully what you experience. Include onset, symptoms and their effect on daily activities

____
____
____

Past treatments/tests____

What helps? ______________________ What hinders? ______________________

Practitioners involved in health care ______________________

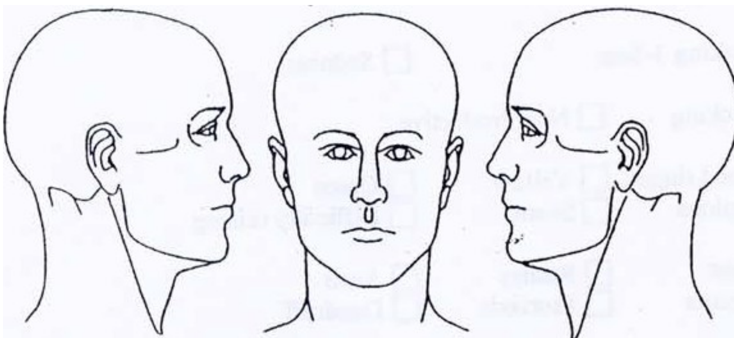
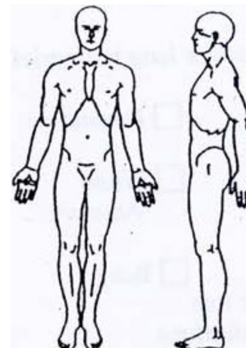
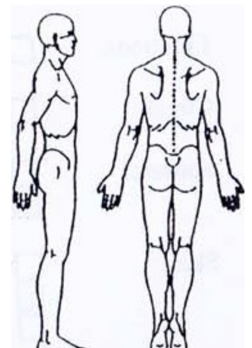
Pain:

Onset:	☐ Rapid	☐ Gradual		
Quality:	☐ Dull	☐ Burning	☐ Sharp	☐ Heavy
Location:	☐ Joint ☐ Fixed	☐ Muscle ☐ Moving	☐ Low back ☐ Radiating	☐ Under ribs
Headache:	Location	☐ Side ☐ Frontal	☐ Top	☐ Occipital
	Frequency	☐ Daily	☐ Weekly_	

Rate the severity of your condition. Circle the box using scale with "10" as unbearable.

1	2	3	4	5	6	7	8	9	10

Indicate location of condition:

Your Lifestyle

O Alcohol
O Marijuana
O Stress
O Tobacco
O Drugs
O Occupational Hazards: ____________________
O Exercise: Type:____________________Frequency:____________

Past Medical History

Mark conditions you have; (1) if bad (2) medium (3) slight

O Accidents
O Aids/HIV
O Alcoholism
O Allergies
O Anxiety
O Appendicitis
O Arteriosclerosis
O Arthritis
O Asthma
O Cancer
O Carpal Tunnel
O Chicken Pox
O Depression
O Diabetes
O Emphysema
O Epilepsy
O Glaucoma
O Goiter
O Gout
O Heart Disease
O Hepatitis
O Herpes
O High Blood Pressure
O Irritable Bowel
O Low Blood Pressure
O Lupus
O Measles
O Multiple Sclerosis
O Mumps
O Pacemaker
O Pleurisy
O Pneumonia
O Polio
O Prostate Disease
O Rheumatic Fever
O Scarlet Fever
O Seizures
O Stroke
O Thyroid Disease
O Tuberculosis
O Typhoid Fever
O Ulcers
O Varicose Veins
O Venereal Disease
O Whooping Cough
O Fibromyalgia
O Other (specify
____
____

List Surgeries:
____
____
____
____

Major Trauma:
____
____
____
____

List Medications, Vitamins, Herbals:
____
____
____

Family Medical History

O Arteriosclerosis
O Asthma
O Alcoholism
O Cancer
O Depression
O Diabetes
O HighBloodPressure
O Seizures
O Stroke
O Thyroid Disease

Review of Systems

Lung

Perspiration: O Scant O Profuse O Daytime O Nighttime O Upper body O Lower Body O Spontaneous O Other__________

Nose: O Stuffy O Dry O Congested O Nosebleeds O Sinus infections O Shortness of breath O Difficulty inhaling O Difficulty exhaling O Difficult breathing while lying down O Wheezing D Sneezing O Frequent colds and flus O Allergies

Emotions O Recent loss or long term grief O Waking 3-5am D Sadness

Cough: O Dry O Productive O Hacking D Non Productive

Sputum: O Clear O White O Blood tinged O Yellow D Green O Rusty Amount: O Copious O Scant O Difficulty raising

Skin: D Dry D Itchy O Moist O Eczema O Rashes O Fungal infections O Psoriasis O Acne O Dandruff

Review of Systems (cont'd)

Kidney/Urinary Bladder

Urine: O Light O Bloody O Dark O Clear O Cloudy O Sand or grit O Sweet odor O Painful urination

Frequency: O _/day O Strong odor O Urgency O Hesitancy O Weak flow

Amount: O Dribble O Intake= Output O Urinary incontinence

Pain: O Low back O_1night O Cold feet O Worse in a.m. O Worse in p.m.

Sexual desire: O Low 0 Intermittent O Impotence O Premature Ejaculation

O Weak knees

0 High

Energy: O Lack of stamina O Need lots of sleep

Hearing: O Hearing loss O Tinnitus (low humming) O Vertigo O Dizziness

Emotions: O rear O Disgruntled O Easily defeated O Diminished motivation

Hair: O Loss/thinning O Dry O Premature gray

Liver

Eyes: O Vision change O Blurred vision O Night blindness O Red
O Dry O Gritty O Floaters O Itchy O Watery
O Painful O Pressure O Vertex Headache O Bitter taste in mouth

Pain: O Muscle cramps/spasms O Pain in ribs, groin, pelvis O Tension pain shoulders, neck
O Tremors, shaking O Nausea from hunger O Hard, dry stools
O Brittle hair or nails O Testicular pain O Hernia O Seizures

Emotion: O Irritable O Sensitive to noise, wind O Loud ringing in ears O Depression
O Tics O Weak, dizzy,-flushed from tension or hunger
O Sensation of something in throat O Frequent sighing or yawning

Heart

O Palpitations O Dizziness O Poor memory O Tongue ulcers O Insomnia
O Easily confused O Lack of focus O Hard to fall asleep O Anxiety
O Difficult to stay asleep O Restlessness
O Mood swings
O Easily overheats or chills O Slight exertion causes heat O Fainting
O Chest pain O Irregular heartbeat O Swelling of hands/feet O Shortness of breath
O Mania/delirium O Dream disturbed sleep O Hot flashes

Gastrointestinal Stomach/Spleen

Mouth: O Bleeding gums O Sour regurgitation O Tooth pain O Dry mouth
O Drooling O Bad breath O Root canals x__ O Silver fillings

Appetite: O Poor O Always hungry O Weight gain O Weight loss
O Fatigue after meals O Hungry with no desire to eat O Hungry after meals

Cravings: O Bitter O Bland O Sweet O Sour O Salty

Thirst: O Room temperature O Cold 0 Hot O No relief with drinks
O Thirst with no desire to drink

Fluids/nutri: O **Edema** Heavy feeling in: O Body O Head O Limbs

Review of Systems (coot'd)

Gasc:roin ts!in2l Stomach/Spleen (cont'd)

Digestion: O Gas O Belching_ O Nausea O Vomiting O Cram O Indigestion
O Slow digestion D Abdominal distention O Bloating U Acid regurgitation

Location: ______
[] Worse after eating O Stress induced O Better with food

3G\·Ve!s: Bowel movements _/day; /wk When?
O Change in pattern O constipation D.,Diaahrea
n Brown O Black O Coffee grounds O Blood
O Mucus O Undigested foods O Foul odor
CJ Hard O Hemorrhoids O Anal itching O Anal burning
O Sticky/pasty O Urgency O Unfinished feeling

Bady: Temperature: O Cold hands O Cold feet
O Lethargy O Organ prolapse O Easy bruising
O Lack of muscle strength or tone in abdomen, back, neck

i:mDtior. s : LJ Easily worried O Overwhelmed by details O Over thinking
O Melancholy O Upset by change O Easily angered

Male:
Please explain details.

History of Prostate disease

Reduced erectile function.

Low desire

Difficulty maintaining erection

No erections

Sensitivity of Penis or testicles.

Female

_Age menses began Duration of flow # Live births
_Days of cycle (day I· day 1) _# pregnancies _#miscarriages
#abortions

Date of last period
Are you/could you:-be pregnant O Yes O No
Method of contraception__________

O Early menstrual cycle (<21 days) O Late menstrual cycle (> J Sdays)
O Irregular menstrual cycles

O Light O Moderate O Heavy Color: O Light red O Dark red
O Bright red O Purple
O Brown

Clots: O Small D Large 0Few
O Many O Dark

Cr2.:n"0s: O Before O During O After O Breast soreness

Vag disch : n Odor O No Odor O White O Clear O Yellow O Bloody

\enopause: Age at menopause_ Menopausal signs: O Hot flash O Night sweats
O Post-menopausal O Mood swings O Forgetful
Cy History O Ovarian cysts O Date last PAP

O Fibroids
O Painful intercourse
O Vaginal burn/itch
O PfD
O Vag dryness
O Vaginal sores
O Venereal disease
O Uterine prolapse