MEDICATIONS: _____

DRUG ALLERGIES: _____

Medical History

HOSPITALIZATIONS:

❑ Ringing In Ear _____
❑ Ear Infections - *Frequent* _____
❑ Dizziness/Fainting _____
❑ Failing Vision _____
❑ Eye Infections _____
❑ Nose Bleeds _____
❑ Sinus Trouble _____
❑ Sore Throats - *Frequent* _____
❑ Hayfever/Allergies _____
❑ Pneumonia _____
❑ Bronchitis/Chronic Cough _____
❑ Asthma/Wheezing _____
❑ Chest Pain _____
❑ High Blood Pressure _____
❑ Heart Murmur _____
❑ Swollen Ankles _____
❑ Leg Pain - *Walking* _____
❑ Varicose Veins/Phlebitis _____
❑ Loss of Appetite _____
❑ Difficulty Swallowing _____
❑ Indigestion or Heartburn _____
❑ Persistent Nausea/Vomiting _____
❑ Peptic Ulcers _____
❑ Abdominal Pain - *Chronic* _____

❑ Gall Bladder Trouble _____
❑ Jaundice/Hepatitis _____
❑ Change in Bowel Habits _____
❑ Diarrhea ❑ Constipation _____
❑ Diverticulosis ❑ Crohn's/Colitis _____
❑ Bloody or Tarry Stools _____
❑ Hemorrhoids _____
❑ Hernia _____
❑ Urine Infections - *Frequent* _____
❑ Blood In Urine _____
Urination-❑ Overnight > than twice
❑ Painful ❑ Loss of Control
❑ Decrease in Force/Flow
❑ Kidney Stones _____
❑ Venereal Disease _____
❑ Urethral Discharge _____
❑ Chronic Fatigue _____
❑ Weight Loss - *Recent* _____
❑ Anemia ❑ Bruise Easily _____
❑ Cancer _____
❑ Diabetes _____
❑ Thyroid Disease _____
❑ Convulsions/Seizures _____
❑ Stroke _____

❑ Tremor/Hands Shaking _____
❑ Muscle Weakness _____
❑ Numbness/Tingling Sensations _____
❑ Headaches - *Frequent* _____
❑ Arthritis/Rheumatism _____
❑ Osteoporosis _____
❑ Back Pain - *Recurrent* _____
❑ Bone Fracture/Joint Injury _____
❑ Gout _____
❑ Foot Pain ❑ Cold Numb Feet _____
❑ Rashes ❑ Hives _____
❑ Psoriasis ❑ Eczema _____
❑ Nervousness ❑ Depression _____
❑ Memory Loss _____
❑ Moodiness - *Excessive* _____
❑ Phobias _____
❑ Mental Illness _____
❑ Lactose Intolerance _____
❑ Prostate Disease _____
❑ Sexual/Menstrual Dysfunction _____
❑ Frequent Infections _____
❑ Diphtheria _____
❑ Tetanus _____
❑ Chicken Pox ❑ Polio ❑ Mumps ❑

Measles ❑ Rubella ❑ Rheumatic Fever
❑ Scarlet Fever ❑ Tuberculosis ❑ Herpes
❑ Other _____
❑ Other _____

Females - *Please Complete*
Pregnant? ❑ Yes ❑ No
Planning Pregnancy? ❑ Yes ❑ No
Menstrual Flow:
❑ Regular ❑ Irregular ❑ Pain/Cramps
____Days of Flow ____Length of Cycle
Date-1st day of last period_____
❑ Pain/Bleeding during or after sex
Number of:
____Pregnancies ____Abortions
____Miscarriages ____Live Births
Birth Control Method_____
B.C. Pill (Name) _____
❑ Flushing/Menopause
Date of Last PAP Test _____
❑ Normal ❑ Abnormal
Date of Last Mammogram
❑ Normal ❑ Abnormal

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS				BLOOD DISEASE	
				GLAUCOMA	
				EPILEPSY	
SPOUSE				RHEUMATOID	
				ARTHRITIS	
CHILDREN				TUBERCULOSIS	
				GOUT	
				HIGH BLOOD PRESSURE	
				HEART DISEASE	
				BACK PROBLEMS	