Name _____ Birth date _____ Age _____ Ht. _____ Wt. _____
Address _____ City _____ State _____ Zip _____
Daytime Phone _____ Evening Phone _____ Email _____
In Emergency Notify _____ Phone _____ Relationship _____
Physician _____ Date of last exam _____
Occupation _____ Referred by _____

Personal Medical History

Please circle if you have a history of any of following conditions

Abuse survivor, ADD, ADHD, Addictions, Addisons, AIDS, Anemia, Anxiety, Arthritis, Asthma, Arteriosclerosis, Autoimmune diseases (RA, Lupus, M.S., other) Bleeding disorders, Birth trauma, Bronchitis, Cancer, Cardiac pacemaker, Chest pain, Chronic fatigue, Chronic pain, COPD, Chronic cough, Diabetes, Depression, Emphysema, Fibromyalgia, Glaucoma, Gallbladder disease, Goiter, Gout, High blood pressure, Heart disease, High cholesterol, Hepatitis, Herpes simplex, Herpes zoster, Hypoglycemia, IBS, Irregular heart rhythm, Kidney disease, Migraine, Mental illness, Polio, Pleurisy, Pneumonia, PTSD, Rheumatic fever, Stroke, TB, Seizures, Thyroid disease, Ulcers, Venereal disease, Whooping cough, Other _____

Family Medical History

Please circle any condition experienced by your parents, grandparents, or siblings

Addictions, Allergies, Autoimmune diseases, Bleeding disorders, Cancer, Diabetes, Depression, Heart Disease, High blood pressure, Migraine, Mental illness, Stroke, High cholesterol, Other_____)

Surgeries, Injuries, Severe illnesses

_____
_____
_____
_____
_____
_____

Allergies

_____
_____

Medications and Supplements

Please bring a list of all prescription medications, nutritional and herbal supplements and any over the counter medications you are currently taking.

Review of Systems
Please circle any symptom you have experienced in the last 6 months

General
Weight loss or gain, Fatigue, Fever or chills, Weakness, Trouble sleeping, Other_____
Skin
Rashes, Lumps, Itching, Dryness, Color changes, Hair and nail changes, Other_____
Head and Neck
Headache, Head injury, Lumps, Swollen glands, Neck Pain or Stiffness, Other_____
Ears, Eyes, Nose, Throat
Decreased hearing, Ringing in ears, Earache, Drainage, Vision Loss/Changes, Cataracts, Glasses or contacts, Pain, Redness, Blurry or double vision, Last eye exam_____
Stuffiness, Discharge, Nosebleeds, Sinus pain, Dentures, Sore tongue, Dry mouth,
Sore throat, Hoarseness,Thrush, Non-healing sores, Grinding of teeth, Jaw pain or clicking,
Other_____
Respiratory
Cough, Sputum, Coughing up blood, Shortness of breath, Wheezing, Other _____
Cardiovascular
Chest pain or discomfort, Tightness, Palpitations, Shortness of breath with activity
Difficulty breathing lying down, Sudden awakening from sleep with shortness of breath
Calf pain with walking, Leg cramping, Varicose veins, Easily bruise, Easily bleed,
Other_____
Gastrointestinal
Swallowing difficulties, Heartburn, Change in appetite, Nausea, Change in bowel habits,
Rectal bleeding, Constipation, Diarrhea, Gas and bloating, Abdominal cramping,
Other_____
Genitourinary
Frequency, Urgency, Burning or pain, Blood in urine, Incontinence, Kidney stones,
Change in urinary strength, Decreased sex drive, Erectile dysfunction, Prostate problems,
Nervous legs at night, Infertility, Other_____
Musculoskeletal
Muscle, joint, tendon or ligament pain, Stiffness, Redness of joints, Swelling of joints,
Trauma
Other_____
Neuropsychological
Dizziness, Fainting, Seizures, Weakness, Numbness, Tingling, Tremor, Tics, Nervousness,
Anxiety, Easily stressed, Abuse survivor, Memory loss, Loss of coordination, Attempted or
considered suicide, Currently seeing a counselor, Other_____

Please describe frequency and amount

Tobacco_____Alcohol_____Recreational drugs_____ Soda_____
Artificial sweeteners_____Fast foods_____ Caffeine_____
Corn syrup_____ Over the counter medications_____
Soy_____Corn_____Wheat_____Other grains_____
Dairy_____Meat_____Fish_____ Vegetables_____
Fruits_____Nuts_____ Types of cooking oils used_____
Exercise (Type and frequency)_____
_____
Prayer, Meditation, Contemplation or Quiet solitude_____
Hobbies_____
Occupational hazards_____
Stress_____
How would you describe your life, (your childhood, relationships, satisfaction with work and play, your goals, accomplishments, joys and sorrows)_____
_____
_____
_____
_____
_____
_____
_____
List your five favorite foods or beverages_____
List five foods or beverages you do not like_____
Describe your sleep patterns:_____
How is your overall energy, vitality:_____
How is your appetite:_____
Do you frequently experience: Grief___ Melancholy___Fears___Anger___Irritability___ Joy__
Do you have any problems with urination:_____
How often do have a bowel movement_____
Do you have any problems with digestion or elimination_____
Are you typically: Thirsty___ Not Thirsty___ Prefer hot or cold liquids_____
Do you sweat: Easily___ Not Easily___ Night Sweats: Yes___ No___ Chills: Yes___ No___
Are your hands or feet typically: Hot_____ Cold____ Normal___
Is there a season or climate that aggravates your symptoms _____

Reason for your visit today:_____
_____
How long have you had this condition_____Is it getting worse_____
Does it interfere with your sleep, work, or other activities_____
What makes it better_____
What makes it worse_____
Have you seen your western medical doctor about this condition_____
Have you been given a diagnosis_____
What treatments have you tried_____
_____
Have your received any relief from these treatments_____
Are you currently receiving any treatments_____With whom_____
Do you have other concerns you wish to address_____
_____
_____
_____
_____

Gynecology

Age at first menses _____ Duration of bleeding ____ days Length of cycle _____ days
Amount of flow (scanty, moderate, heavy, flooding) Clots _____ Mid cycle spotting _____
Mid cycle pain _____ Menstrual cramps or pain _____ Date last period began
_____
Any changes in your menses in the last 3 years
_____
Type of birth control used_____
Vaginal discharge _____ Color _____ Odor _____ Itching _____ Vaginal sores _____
Breast lumps _____ Date of last mammogram _____Date of last PAP test
_____
Number of pregnancies _____- Miscarriages _____ Abortions _____
Any complications with labor or delivery
_____
Age at menopause _____ Any menopausal difficulties
_____

Please circle any symptoms you have and indicate whether they occur prior, during or after menstruation.

A. Nervous tension Mood swings Irritability Anxiety **B.** Weight gain
Swelling of extremities Breast pain Abdominal bloating **C.** Headache Cravings
Increased appetite Fatigue Heart pounds Dizziness **D.** Depression Forgetfulness
Crying Confusion Insomnia