

Medical History

All information is confidential and shall not be shared without your written consent.

Name _____ Today's Date _____
Date of Birth _____ Place of Birth _____ Age _____
Address _____
Work Phone _____ Home Phone _____
Cell Phone _____ Email _____
Can I contact you at work? _____ Can I email you? _____
Emergency Contact (name and phone #) _____
How did you hear about this clinic? _____
Do you or have you ever been diagnosed with HIV/AIDS, Hepatitis B, Hepatitis C? _____

Recent tests: (please indicate test results and date below)

<input type="checkbox"/> Physical	<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Prostate	<input type="checkbox"/> Blood (which?)
<input type="checkbox"/> HIV/STD	<input type="checkbox"/> Pap smear	<input type="checkbox"/> Mammography	<input type="checkbox"/> Other: _____

Test Results and Date: _____

Check any you have had in the past:

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Allergies	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> CVA (stroke)	<input type="checkbox"/> Vein condition	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Mumps	<input type="checkbox"/> Bleeding tendency
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Measles	<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Nervous disorder
<input type="checkbox"/> Meningitis	<input type="checkbox"/> HIV	<input type="checkbox"/> Polio	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High fever	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> other lung illnesses	<input type="checkbox"/> other liver illnesses	<input type="checkbox"/> other heart illnesses	<input type="checkbox"/> other kidney illnesses
<input type="checkbox"/> other: _____			

Immunizations: _____

Surgeries: _____

History of frequent antibiotic use? Yes No

Major Complaint(s), in order of significance to you: [Next to each complaint provide the following information: 1. How long you have been suffering with this condition? 2. How often does this complaint bother you? 3. At it's worst, describe exactly what happens or how it feels. 4. How long does it last when it is at its worst?]

Complaint(s):

(1). _____

- 1. _____
- 2. _____
- 3. _____
- 4. _____

(2). _____

- 1. _____
- 2. _____
- 3. _____
- 4. _____

(3). _____

- 1. _____
- 2. _____
- 3. _____
- 4. _____

(4). _____

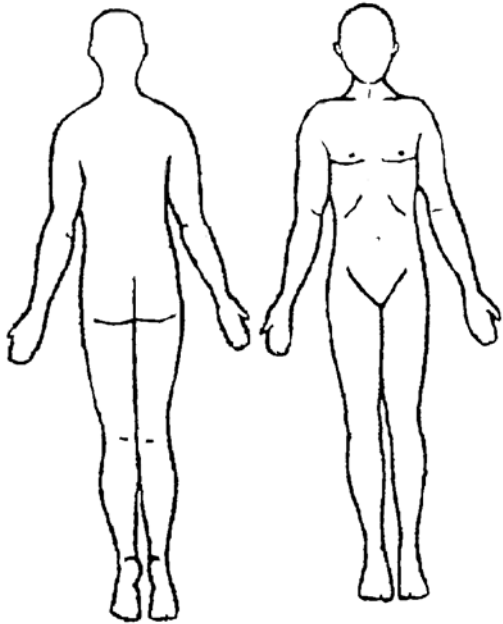
- 1. _____
- 2. _____
- 3. _____
- 4. _____

(5). _____

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Have you been given a diagnosis for any of these conditions? _____

What kind of treatments have you tried, and to what extent have they helped you? _____



GRID

NUMB	ooo	BURN	+++
ACHE	◆◆◆	PINS	
SHARP	△△△	DULL	---
MOVING	zzz	FIXED	□□□
OTHER	_____		888

Do the following improve the pain?

- Pressure Cold Heat
 Exercise Other _____

*** Using the grid in the upper right hand portion of this page, draw the symbols on the body exactly where you are experiencing your pain***

Pain (check all that apply)

- My pain is unbearable and nothing helps it
- My pain is worse at night
- My pain is worse in the morning
- I take prescribed medication or over the counter medication to control the pain
- I have only minor aches and pains
- I rarely, if ever experience pain

Stress

- My stress levels are high
- My relationship with my partner/spouse causes me great stress
- Work is stressful & I dislike my job
- Many of my health complaints improve when I go on vacation
- I currently am unemployed

Please list quantity and frequency of use for the following items:

Tobacco _____ per _____
 Coffee _____ per _____
 Alcohol _____ per _____
 Sugar _____ per _____

List any recreational or street drugs you use and their frequency _____
 Are you in recovery from a chemical addiction? If so, what type? _____

WOMEN ONLY:

Length of your cycle in days (i.e. average 28-30 days) _____ days

Average number of days of flow _____

Age of first menstruation _____

Bleeding or spotting between periods? Yes No

Pregnant? Yes No

Number of pregnancies _____

Unexplained Infertility? Yes No

Infertility due to structural or physical origin? Yes No

Diagnosis of Endometriosis? Yes No

Ovarian cysts? Yes No Uterine Fibroids? Yes No

Hysterectomy (partial or complete) Date: _____

Are you menopausal? Yes No

Do you have early menopausal symptoms? Yes No

Other conditions or procedures you would like to mention _____

Do you experience any of the following pre-menstrual syndromes?

- nausea vomiting water retention breast swelling
- food cravings headaches migraines breast tenderness
- depression irritability anxiety other emotions: _____
- dull pain, where? _____ sharp pain, where? _____

Please fill in the following menstrual chart:

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Color (normal, bright red, pale, brown, rust, dark, purple, other)							
Amount of flow (normal, heavy, light)							
Pain/cramps (location, dull, sharp, other)							
Clots (large, small, black, purple, red, other)							
Vomiting (check if yes)							
Nausea (check if yes)							
Other							

Feel tired after your period

Feel better during menses