Patient Name:_____

Past Medical History

Check any of the following conditions you currently have or have had in the past. Please also check if you feel any of the following are a significant part of your medical history.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Birth Trauma (your own birth)
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Measles
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Whooping Cough
- ☐ Other (specify)

_____
_____
_____

List medications you are currently taking:
Medications Strength How many per day For how long

_____
_____
_____
_____

List substances or medications you are allergic to:

_____
_____

List any major surgeries you have had:
Date Problem

_____
_____
_____

List significant trauma you have had (auto accident, falls, etc.):

_____
_____
_____

List significant family history:

_____
_____

Your Diet

Appetite
☐ High ☐ Low

- ☐ Coffee
- ☐ Soft drinks
- ☐ Sugar
- ☐ Salty food

Thirst for water:
# of glasses per day: _____

Vitamins taken in the past two months:

_____
_____
_____

Your Lifestyle

- ☐ Alcohol
- ☐ Tobacco
- ☐ Marijuana
- ☐ Drugs
- ☐ Stress
- ☐ Occupational Hazards
- ☐ Regular Exercise
  Type:_____ Frequency: _____
  Type:_____ Frequency: _____

General Symptoms

- ☐ Poor appetite
- ☐ Heavy appetite
- ☐ Strongly like cold drinks
- ☐ Strongly like hot drinks
- ☐ Recent weight loss
- ☐ Recent weight gain
- ☐ Poor sleep
- ☐ Healthy sleep
- ☐ Dream-disturbed sleep
- ☐ Fatigue
- ☐ Lack of strength
- ☐ Bodily heaviness
- ☐ Cold hands or feet
- ☐ Poor circulation
- ☐ Shortness of breath
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Sweats easily
- ☐ Muscle cramps
- ☐ Vertigo or dizziness
- ☐ Bleed or bruise easily
- ☐ Peculiar taste (describe):
  _____

Head, Eyes, Ears, Nose, and Throat

- ☐ Glasses
- ☐ Eye strain
- ☐ Eye pain
- ☐ Red eyes
- ☐ Itchy eyes
- ☐ Spots in eyes
- ☐ Poor vision
- ☐ Blurred vision
- ☐ Night blindness
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Teeth problems
- ☐ Grind teeth
- ☐ TMJ
- ☐ Facial pain
- ☐ Gum problems
- ☐ Sores on lips or tongue
- ☐ Dry mouth
- ☐ Excessive Saliva
- ☐ Sinus problems
- ☐ Excessive phlegm
- ☐ Color of phlegm:
  _____
- ☐ Recurrent sore throat
- ☐ Swollen glands
- ☐ Lumps in throat
- ☐ Enlarged thyroid
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Earaches
- ☐ Headaches
- ☐ Migraines
- ☐ Concussions
- ☐ Other head/neck issues
  _____