

File#:

MEDICAL HISTORY

Do you suffer from:

- | | | |
|---|------------------------------------|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tuberculosis |

Review of systems: (have you experienced any of the following in past 6 months)

EENT

- | | | |
|--|---|--|
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> Vision Problems | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Allergies |

Cardiovascular

- | | | |
|--|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Blood pressure problems | <input type="checkbox"/> Irregular heartbeat |
| <input type="checkbox"/> Lung problems | <input type="checkbox"/> Varicose veins | |

Gastrointestinal

- | | | |
|--|---|--|
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Frequent Nausea |
| <input type="checkbox"/> Appetite problems | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Weight trouble |
| <input type="checkbox"/> Gall Bladder problems | <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Black / Bloody stool | <input type="checkbox"/> Colitis | |

Genitourinary

- | | | |
|--|--|--|
| <input type="checkbox"/> Bladder problems | <input type="checkbox"/> Urine discoloration | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Excessive urination | | |

Nervous System

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Forgetfulness | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Cold / Numbness / Tingling in arms or hands | | |
| <input type="checkbox"/> Cold / Numbness / Tingling in legs or feet | | |

Male / Female

- | | | |
|---|--|--|
| <input type="checkbox"/> Genital herpes | <input type="checkbox"/> Vaginal pain / infections | <input type="checkbox"/> Breast pain / lumps |
| <input type="checkbox"/> Prostate / sexual dysfunction | | |
| <input type="checkbox"/> Menstrual Cramping (excessive) | | |

Females Only

When was your last period? ___/___/___ Are you pregnant? _____

Are you allergic to any medications? ___ Yes ___ No

If so list: _____

Are you taking any medications (prescription or over the counter)? ___ Yes ___ No

If so list: _____

Have you ever been hospitalized? ___ Yes ___ No

If so when and for what: _____

Have you ever had a serious illness? ___ Yes ___ No

If so when and what was the illness: _____

Have you ever experienced any trauma? ___ Yes ___ No

If so when and what type of trauma: _____

Have you ever had any operations? ___ Yes ___ No

If so when and for what: _____

Do you smoke? ___ Yes ___ No If so how many packs per day? _____

Do you drink alcohol? ___ Yes ___ No If so how much per week? _____

Do you exercise on a regular basis? ___ Yes ___ No

Have you had any previous accidents that were:

Work-related?	___ Yes	___ No	If so when?	_____
Motor vehicle?	___ Yes	___ No	If so when?	_____
Slip and fall?	___ Yes	___ No	If so when?	_____

Notes: _____

