MEDICAL HISTORY

DATE _____

SYSTEM REVIEW: Do you currently have

General:

Fever	No	Yes
Night sweats	No	Yes
Recent weight change	No	Yes

Skin:

Skin disease	No	Yes
Hives, eczema or rash	No	Yes
Abnormal pigmentation	No	Yes

Eyes:

Eye disease or injury	No	Yes
Double vision	No	Yes
Macular degeneration	No	Yes
Sudden change in vision	No	Yes

ENT:

Frequent sinus pain	No	Yes
Impaired Hearing	No	Yes
Dizziness or vertigo	No	Yes
Difficulty swallowing	No	Yes

Neck:

Enlarged glands	No	Yes
Neck stiffness	No	Yes
Neck pain	No	Yes
Pain or numbness in hands or arms	No	Yes

Respiratory:

URI (Cold) now	No	Yes
Frequent or chronic cough	No	Yes
Coughing up blood	No	Yes
Difficulty breathing	No	Yes
Asthma or wheezing	No	Yes

Cardiovascular:

Chest pain or angina pectoris	No	Yes
Shortness of breath on exertion	No	Yes
Awakening at night smothering	No	Yes
Irregular heart beat	No	Yes
Heart murmur	No	Yes
Swelling of the ankles or feet	No	Yes

Gastrointestinal:

Heartburn or indigestion	No	Yes
Recurrent abdominal pain	No	Yes
Vomiting food or blood	No	Yes
Passing blood in your stool	No	Yes
Gallbladder problems	No	Yes
Liver problems	No	Yes

Genitourinary:

Frequent urination	No	Yes
Night-time urination	No	Yes
Loss of control of urination	No	Yes
Pain or burning on urination	No	Yes
Blood or pus in urine	No	Yes
Kidney trouble	No	Yes
Kidney stones	No	Yes

Gynecological:

Premenopausal	No	Yes
Post menopausal	No	Yes
Are you currently pregnant or trying to become pregnant	No	Yes

Musculoskeletal:

Joint pain or swelling	No	Yes
Muscle pain or tenderness	No	Yes
Muscle weakness	No	Yes
Difficulty walking	No	Yes
Pain in the calves when walking, relieved by rest	No	Yes
Low back pain	No	Yes
Does it go into your leg(s)	No	Yes

Neurological:

Recurrent headaches	No	Yes
Blank outs	No	Yes
Passing out or fainting	No	Yes
Temporary loss of vision in one eye	No	Yes
Weakness or numbness on one side	No	Yes
Paralysis	No	Yes
Have you ever had a concussion	No	Yes
Have you ever been knocked unconscious	No	Yes

Endocrine:

Thyroid problems	No	Yes
Excessive thirst	No	Yes
Heat or cold sensitivity	No	Yes
Change in hair growth	No	Yes
Do you take hormones	No	Yes

Hematological / Lymphatic:

Anemia	No	Yes
Blood diseases	No	Yes
Phlebitis	No	Yes
Deep vein thrombosis	No	Yes
Abnormal bruising or bleeding	No	Yes

Allergy / Immunologic System:

Frequent sneezing	No	Yes
Do you have any diseases of the immune system	No	Yes

Psychiatric:

Have you ever had psychiatric care	No	Yes
Have you ever been advised to seek psychiatric care	No	Yes
Have you ever been depressed	No	Yes
Have you ever taken medication for any psychiatric problem	No	Yes

_____
Doctor

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Please be sure to fill out both sides.