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**Medical History**

**MEDICAL HISTORY & SYSTEMS REVIEW**  
[ BRING THIS WITH YOU TO YOUR FIRST APPOINTMENT ]

Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
Sex: M/ F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Primary Presenting Health Problems	Began	Treatments Attempted	Treatment Results

What is your primary health goal today?  
\_\_\_\_\_

Current Medications	Dose + Freq	Response

Current Vits./Herbs etc	Dose + Freq	Response

**BLOOD PRESSURE:** What is your most recent blood pressure reading? \_\_\_\_\_/\_\_\_\_\_ Date taken? \_\_\_\_\_

**CHILDHOOD ILLNESS:** (please circle any that you have had):  
Scarlet Fever Diphtheria Rheumatic Fever Mumps Measles German Measles Chicken Pox

**IMMUNIZATIONS:** (please circle any that you have had):  
Polio Tetanus Measles/Mumps/Rubella Pertussis Diphtheria Hepatitis B  
Others: \_\_\_\_\_

**HOSPITALIZATIONS AND SURGERIES:**

Reason	When	Reason	When

**X-RAYS/CAT SCANS, MRI's, SPECIAL STUDIES:**

Reason	When	Reason	When

**MENSTRUAL/BIRTHING HISTORY:**

1. Age of First Menses: \_\_\_\_\_ 4. Birth Control Type: \_\_\_\_\_ 7. # of Abortions: \_\_\_\_\_  
2. # of Days of Menses: \_\_\_\_\_ 5. # of Pregnancies: \_\_\_\_\_ 8. # of Live Births: \_\_\_\_\_  
3. Length of Cycle: \_\_\_\_\_ 6. # of Miscarriages: \_\_\_\_\_

**Do you?? Please check | How Much?**

Smoke Tobacco? _____	Use Caffeine? _____
Drink Alcohol? _____	Chew Tobacco? _____
Drink Sodas? _____	Use Drugs? _____

**List Drug Allergies | Supplement Allergies | Food Allergies | Inhalant Allergies | Chemical Sensitivities**

	Milk Products	Dust	Chlorine, Formaldehyde
	Wheat, Grains	Grass, Trees, Pollen	Cosmetics, Perfumes
	Soy	Mold	Detergents, Cleaners
	Newsprint	Animal Dander	Gas, Glues, Paint, Dye

<b>Injuries:</b>	<b>Date:</b>
<b>Hospitalizations &amp; Surgeries:</b>	<b>Date:</b>
<b>Foreign Travel:</b>	<b>Date:</b>
<b>Parasite Infection:</b>	<b>Date:</b>
<b>Bug/ Animal Bites:</b>	<b>Date:</b>

**Types of Traditional & Complementary (Alternative) Health Care Utilized: Indicate Results with \_ or x. Past and/or Current.**

Chinese Medicine \_\_\_ Naturopathic Medicine \_\_\_ Chiropractic/Tuina \_\_\_ Massage \_\_\_ Physical Therapy \_\_\_  
 \_\_\_ Nutritional Therapy \_\_\_ Herbal Treatments \_\_\_ Cranial Sacral \_\_\_ Colonic \_\_\_  
 Hydrotherapy \_\_\_ Midwifery \_\_\_

**Are you receiving disability payments? \_\_\_\_\_ Are you in litigation over any health problem? \_\_\_\_\_**  
**Is this a Workers Comp case? \_\_\_\_\_ Are you here on behalf of a third party? \_\_\_\_\_**

**Medical History**

**Health History: You and Your Family. \_ any of the following that apply to you and your family - past or present.**

<b>Condition Members/List</b>	<b>You</b>	<b>Family Members/List</b>
Addictions / Alcohol	_____	_____
HIV/AIDS	_____	_____
Addictions / Other	_____	_____
Hormonal Problems	_____	_____
Arthritis	_____	_____
Hyperactivity / ADHD	_____	_____
Anxiety/Depression	_____	_____
Learning Disability/PDD	_____	_____
Asthma / Bronchitis	_____	_____
Muscle Problems	_____	_____
Autoimmune Disease	_____	_____
Neurological Problems	_____	_____
Bladder/Kidney	_____	_____
Psychological Problems	_____	_____
Bone Loss (Osteoporosis)	_____	_____
Rheumatic Fever	_____	_____
Cancer	_____	_____
Sex Transmitted Disease	_____	_____

Diabetes	
Seizure Disorders	
Digestive / Intestinal Prob.	
Sinus / Respiratory	
Ear / Eye Problems	
Skin Prob / Eczema / Acne	
Eating Disorders	
Stroke	
Genetic Condition	
Swallowing Disorder	
Gout	
Thyroid Disease	
Headaches	
TMJ	
Heart Disease	
Viral Disorder	
High Blood Pressure	
Weight Loss or Gain	

**Adult Exams / Tests**

**Date**

**Results**

Complete Physical	
EKG (Cardiogram)	
Hemocult (Stool blood)	
Cardio Stress Test	
Colon Exam	
MRI	
X-Rays	
Dental	
Other:	

Males: Prostate Exam

PSA Test

Bone Loss Screen

Females: Pap Smear

Breast Exam

Mammogram

Last Menses

Bone Loss Screen

**Activity Level**

- Sedentary: Inactive by choice
- Sedentary: Inactive due to inability
- Light: Light daily work, no regular exercise
- Moderate 1: Sedentary work + exercise 3 x week
- Moderate 2: Light daily work + exercise 3 x week
- Sustained: Moderate daily work + exercise 5 x week
- High: Heavy work + heavy exercise 5 x week
- Heavy: Elite athlete. Heavy workouts 20 hrs/ wk

**Rate 0-3 Stressors Affecting Your Life**

- Difficulties with work or lifestyle
- Recent change in marital status
- Death or serious illness among family / friends
- Dysfunctional family past? present/
- Personal illness and coping with illness

Lack of love or fulfilling relationships  
 Feeling lonely, disconnected from others  
 Lack of prayer / spirituality / inner peace

**Review of Systems**

**For "Past": if it applies For "Now" - Rate 0 - 3: 0 = Not present 1 = Mild 2 = Moderate 3 = Severe**

<b>Symptoms</b>	<b>Past</b>	<b>Now</b>	<b>Comments</b>
<b><u>GENERAL IMMUNE</u></b>			
Frequent Fatigue			
Weight "Gain" "Loss" > 10 #			
Hot / Heat Intolerant			
Cold / Cold Intolerant			
Perspire Easily			
Lack of Perspiration			
Frequent Infections			
Immune / Auto-immunity			
History of "Mono" or "EBV"			
Swollen Glands			

<b>Symptoms</b>	<b>Past</b>	<b>Now</b>	<b>Comments</b>
<b><u>ENDOCRINE</u></b>			
Low body temperatures			
Cold Extremities			
Thyroid Disorder			
Dizzy Upon Standing			
Low Blood Pressure			

<b>Symptoms</b>	<b>Past</b>	<b>Now</b>	<b>Comments</b>
<b><u>SKIN / NAILS</u></b>			
Acne, Eczema, Dermatitis			
Brown Spots			
Itching, Burning, Dry			
Oily			
Pale			
White Spots: Loss of Pigment			
Yellow Tone			
Nails: Brittle, Peeling			
Ridges, white lines			

<b>Symptoms</b>	<b>Past</b>	<b>Now</b>	<b>Comments</b>
<b><u>HEAD &amp; NECK</u></b>			
Headaches			
Migraines			
Head Injury			
Face / Jaw Pain			
Neck Pain, Stiff Neck			
Hair: Brittle, Dry			
Hair Loss of Color			
Hair Loss			

<b>Symptoms</b>	<b>Past</b>	<b>Now</b>	<b>Comments</b>
<b><u>EARS</u></b>			
Ear Infections			
Hearing Loss			
Itching			

Hard Ear Wax		
Ringing / Tinnitus		
Nasal		
Bleeds		
Burning / Dryness/Crusts		
Sinusitis		
Sense of Smell Loss		

**Symptoms** **Past** **Now** **Comments**

**MOUTH / THROAT**

Bleeding Gums		
Bone Loss (Periodontitis)		
Bruxism (Grinding)		
Face / Jaw Pain / TMJ		
Fillings: Silver / Mercury		
Lip Cracks		
Mouth Ulcers		
Swallowing Problems		
Hives / Rashes Taste Loss		
Tongue coated		
Tongue Fissured		
Voice Hoarse		

**Symptoms** **Past** **Now** **Comments**

**DIGESTIVE**

Belching, Bloating, Gas		
Colitis / Irritable Bowel		
Constipation		
Diarrhea		
Gastritis, Pain, Ulcer		
Heartburn, Reflux		
Hemorrhoids/Rectal Bleed		
Liver/Gall Bladder Problem		
Nausea / Vomiting		
Stool: Dark green?		
Black ?		
Blood?		
Mucous?		
Yellow?		

**Symptoms** **Past** **Now** **Comments**

**EYES**

Wear Glasses		
Blurred Vision		
Blood Shot		
Burning / Dry / Itching		
Cataracts		
Floaters (see spots)		
Glaucoma / Retina Problems		
Lids Crusty		
Light Sensitive		
Night Blindness		

**Symptoms** **Past** **Now** **Comments**

**RESPIRATORY**

Asthma		
Bronchitis		



Cramps			
Heavy Flow			
Irregular			
Infertility			
Peri-menopausal			
Menopausal:			
Natural			
Surgical			
Night Sweats			
<b>Osteoporosis</b>			
Ovarian/Uterine Cancer			
Painful Intercourse			
Pap Smears – abnormal			
Pre-Menstrual Tension			
Pregnancies:			
Incomplete			
Full Term			
Sexually Transmitted Disease			
Vaginal:			
Dryness			
Infection			
Inflammation			
Yeast			

**Symptoms** **Past** **Now** **Comments**

**URINARY**

Bladder Infections - frequent			
Blood in Urine			
Frequent Urination			
Incontinence			
Kidney Stones			
Pain, Burning			

**Symptoms** **Past** **Now** **Comments**

**BEHAVIOR/PSYCHOLOGY**

Addictions (list)			
Anxiety			
Attention Deficit (ADD)			
Bizarre Behavior			
Depression			
Developmental Delays			
Eating Disorder (list)			
Fearful / Worrier			
Hyperactivity / Manic			
Insomnia			
Lack of Dream Recall			
Learning Problems			
Memory Problems			
Mood Swings			
Narcolepsy – Oversleeping			
Obsessive / Compulsive			
Phobias			
Schizophrenia			
Suicidal			

**Symptoms** **Past** **Now** **Comments**

**GLUCOSE CONTROL**

Afternoon Drowsiness

Cravings:

Butter/Fats

Foods (list)

Ice

Fatigue After Eating

Hunger Headaches

Hunger Irritability

Skin Crawling Sens

Symptoms from Foods


**Symptoms**

**OTHER**

Best time of the day

Worst time of the day

Best season for you

Worst season for you

**Past**

**Now**

**Comments**

<b>Past</b>	<b>Now</b>	<b>Comments</b>