

Past Medical History

Name: _____ Today's Date: _____

There is space at the end of this form to write additional comments or for added detail if necessary.

Approximant date of your last exam: _____ Did it include: Blood Analysis Urine Analysis Pap Smear

Results: NORMAL ABNORMAL (list the findings and recommendations): _____

Height: _____ Weight: _____ Realistically, how much do you want to weigh? _____

Are you RIGHT or LEFT hand dominate? _____

Any surgeries or hospitalization? NO YES (for what and how long?) _____

Have you ever had treatment to any of these areas: NECK LOWER BACK UPPER BACK SPINE
NERVE CONDITION SCIATICA OTHER MUSCULOSKELETAL CONDITION: _____

If so, name the condition(s) and briefly explain how it was treated, for how long and did the condition resolve or are there residual problems as a result of the condition: _____

Have you had any x-rays of the neck or spine? NO YES If so, where were they taken: _____

Have you ever been given a disability or impairment rating or do you have a disability: NO YES
(explain): _____

Have you ever been knocked unconscious? NO YES (how. how long ago and how long were you out?) _____

Have you ever fractured a bone? NO YES (If yes, what, when and outcome?) _____

If you have had any surgeries, fractures, accidents, injuries, concussions etc. are there any residual problems or were there any residual complications the you haven't mentioned above? _____

In the past **5 years** have you had any problems, conditions or illnesses in the following areas:

HEART/CIRCULATUION HEAD THROAT EYES/EARS/NOSE/SINUS STOMACH/DIGESTION
ELIMINATION SKIN ARMS/LEGS REPRODUCTIVE ORGANS

In the past **5 years** have you had any problems with: ANXIETY DEPRESSION IRRITABILITY
NERVOUSNOUS If so, did you receive treatment or therapy? NO YES If yes, by a:

PSYCHIATRIST PSYCHOLOGIST COUNSELOR Other: _____ Treated With:
MEDICATION BIOFEEDBACK COUNSELING Other: _____

Please Mark the Following you have experienced in the past **5 years**:

- | | | |
|--|---|--|
| <input type="checkbox"/> Unexplained Fevers | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Weight Loss over 10 Pounds |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Easily Bruise | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Lumps in Neck | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Persistent/ Unusual Cough |
| <input type="checkbox"/> Lumps in Breast/Arm pit | <input type="checkbox"/> Swelling in Joints | <input type="checkbox"/> Pain in Joints |
| <input type="checkbox"/> Morning Stiffness | <input type="checkbox"/> Muscle Tenderness | <input type="checkbox"/> Persistent Redness in Eyes |
| <input type="checkbox"/> Trouble Breathing Laying Flat | <input type="checkbox"/> Chest Pain/ Tightness | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Ears Ringing or Buzzing | <input type="checkbox"/> Weight Gain over 20 lbs in one year |
| <input type="checkbox"/> Excessive Fatigue | <input type="checkbox"/> Stomach Pain | <input type="checkbox"/> Skin Rashes |
| <input type="checkbox"/> Dryness in Mouth | <input type="checkbox"/> Increased Frequency in Urination | <input type="checkbox"/> Unexplained Dizziness or Vertigo |

Please mark any of the following conditions you have **ever** had:

- Allergies
- Anemia
- Arthrosclerosis
- Arthritis
- Diabetes
- Emphysema
- Epilepsy
- Gout
- Heart Disease
- Miscarriage
- Multiple Sclerosis
- Stroke or Tia
- Ulcers
- Cancer
- Asthma
- _____

Family History: please connect all that apply. Unknown family history

High Blood Pressure
 Diabetes
 Strokes
 Cancer
 Heart Conditions

EXAMPLE

Mother, Maternal Grandmother or Aunt
 Maternal Grandfather or Uncle
 Father, Paternal Grandmother or Aunt
 Paternal Grandfather or Uncle
 Siblings

Mental/Emotional Disorders

How is your appetite? TOO GOOD NORMAL NOT GOOD NO APPETITE

Do you feel you have a well balanced diet? NO YES UNCERTAIN

Do you eat a lot of junk food or fast food? NO YES

Do you eat plenty of whole grains, raw fruit and vegetables? NO YES List the vitamins or supplements you take: _____

Do you smoke? NO YES Packs per day? _____ How many years (total if off and on)? _____

If you quit, how long ago? _____ Do you use other tobacco? _____

Do you drink more than two cups of coffee or two sodas per day? NO YES How much? _____

Do you drink alcohol? NO YES If yes, how much: 1 or 2 3 or more How often: _____ days per: WEEK MONTH YEAR

Do you use recreational drugs? NO YES How often? DAILY WEEKLY MONTHLY Do you have good sleep habits? NO YES On average, how many hours per night of sleep do you get? _____ Do you have a firm mattress? NO YES

Do you have any routine activities? (exercise, walk the dog, tennis, jog etc.) How many times per week and how long? _____

WOMEN:

Any current problems with: SPOTTING INTENSE CRAMPS or PAINFUL MENSTRUAL PERIODS BACK PAIN ASSOCIATED WITH PERIOD HEADCHES WITH CYCLE BREAST TENDERNESS OTHER MENSTRAL PROBLEMS: _____

Number of pregnancies: _____ Is it possible you are pregnant? NO YES TRYING UNCERTIAN

Have you had any menopausal symptoms? NO YES UNCERTIAN GOING THROUGH IT BEEN THERE DONE THAT

Are there any other comments regarding you health you want the Doctor to know?

