Have you ever had, or have now, any of the following ?

- ☐ FREQUENT HEADACHES
- ☐ DECREASED HEARING
- ☐ FREQUENT EAR INFECTIONS
- ☐ DIZZY SPELLS
- ☐ DOUBLE OR BLURRED VISION
- ☐ FREQUENT EYE INFECTIONS
- ☐ RECURRENT NOSE BLEEDS
- ☐ SINUS TROUBLE
- ☐ FREQUENT SORE THROATS
- ☐ HAY FEVER/ALLERGIES
- ☐ PROLONGED HOARNESS
- ☐ PNEUMONIA/PLEURISY
- ☐ BRONCHITIS/CHRONIC COUGH
- ☐ ASTHMA/WHEEZING
- ☐ SHORTNESS OF BREATH OR EXERTION
- ☐ SHORTNESS OF BREATH LYING FLAT
- ☐ COUGHING OF BLOOD
- ☐ NIGHT SWEATS
- ☐ CHEST PAIN
- ☐ HEART PALPITATIONS
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART MURMURS
- ☐ SWOLLEN ANKLES
- ☐ FAINTING SPELLS
- ☐ LEG PAIN WHEN WALKING
- ☐ VARICOSE VEINS/PHLEBITIS
- ☐ DIFFICULTY SWALLOWING
- ☐ INDIGESTION OR HEARTBURN
- ☐ PERSISTANT NAUSEA/VOMITING
- ☐ PEPTIC ULCERS
- ☐ ABDOMINAL PAIN-CHRONIC
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ DIVERTICULOSIS
- ☐ BLOODY OR TARRY STOOLS
- ☐ HEMORRHOIDS
- ☐ GALL BLADDER TROUBLE
- ☐ JAUNDICE/HEPATITIS
- ☐ HERNIA
- ☐ KIDNEY STONES
- ☐ FREQUENT URINE INFECTIONS
- ☐ PAINFUL URINATION
- ☐ BLOOD IN URINE
- ☐ OVERNIGHT URINATION MORE THAN 2
- ☐ CONTROL IN URINATION
- ☐ DECREASE IN FORCE OF URINATION
- ☐ VENEREAL DISEASE
- ☐ URETHRAL DISCHARGE
- ☐ CHRONIC FATIGUE
- ☐ RECENT WEIGHT LOSS
- ☐ ANEMIA
- ☐ BRUISE EASILY
- ☐ CANCER
- ☐ DIABETES
- ☐ THYROID DISEASE
- ☐ CONVULSIONS/SEIZURES
- ☐ STROKE
- ☐ TREMOR/HAND SHAKING
- ☐ MUSCLE WEAKNESS
- ☐ NUMBNESS/TINGLING SENSATIONS
- ☐ ARTHRITIS/RHEUMATISM
- ☐ RECURRENT BACK PAIN
- ☐ BONE FRACTURE
- ☐ GOUT
- ☐ FOOT PAIN
- ☐ COLD NUMB FEET
- ☐ RASHES
- ☐ PSORIASIS
- ☐ ECZEMA
- ☐ NERVOUSNESS
- ☐ DEPRESSION
- ☐ MEMORY LOSS
- ☐ EXCESSIVE MOODINESS
- ☐ PHOBIAS
- ☐ MENTAL ILLNESS
- ☐ CHICKEN POX
- ☐ MEASLES
- ☐ SLEEPING DIFFICULTY
- ☐ MUMPS
- ☐ POLIO
- ☐ SCARLET FEVER
- ☐ WHOOPING COUGH
- ☐ TUBERCULOSIS
- ☐ FREQUENT COLDS
- ☐ ALCOHOL USE _____oz DAILY
- ☐ SMOKING _____ PACKS DAILY
- ☐ COFFEE _____ CUP DAILY
- ☐ DRUG ALLERGY
- ☐ OPERATIONS:

_____
_____
_____
_____
_____

FEMALE ONLY-MENSTRUAL HISTORY

AGE OF ONSET _____

PERIODS: _____ REGULAR
_____ IRREGULAR

FLOW: _____ HEAVY
_____ LIGHT
_____ MODERATE

PAIN/CRAMPS WITH FLOW _____ _____
YES NO

No. OF DAYS OF FLOW _____
LENGHT OF CYCLE _____
PAIN/BLEEDING AFTER SEX _____
No. OF PREGNANCIES _____
No. OF BIRTHS _____
No. OF MISCARRIAGES _____
BIRTH CONTROL METHOD _____
NAME OF BIRTH CONTROL PILL _____
FLUSHING/MENOPAUSE _____
DATE OF LAST PERIOD _____
SPOTTING/BLEEDING BETWEEN PERIODS ____ ____
YES NO

FAMILY HISTORY

List any relations that have or had any of the following
(Ex.: Grandmother, Brother, Sister, etc...)

TUBERCULOSIS _____
STROKE _____
MIGRAINE _____
MENTALL ILLNESS _____
EPILEPSY _____
DIABETES _____
CANCER _____
ALLERGIES _____
ARTHRITIS _____
KIDNEY DISEASE _____
GLAUCOMA _____
HIGH BLOOD PRESSURE _____
HEART ATTACK _____

NAME _____ DATE _____ DATE OF BIRTH _____

MEDICAL HISTORY QUESTIONAIRE