PERSONAL MEDICAL HISTORY

Last Name	First	Middle	DOB	Education

Address	City	State	Zip	Home Phone	Business

Occupation	Religion	Sex	Marital Status

Date of last physical examination:	Physician:

Family History		Living		Deceased	
Family Member	Sex	Age	Medical Problems	Age at Death	Cause
Father:					
Mother:					
Siblings:	M F				
	M F				
	M F				
	M F				
	M F				
	M F				
Husband/Wife:	M F				
Children:	M F				
	M F				
	M F				
	M F				

Do you know of any blood relative who had or currently has the following: (circle and give relationship)

Stroke	Heart Attack	Epilepsy
Cancer		Suicide
High Blood Pressure	Migraine	Ulcers
Tuberculosis	Asthma	Kidney Disease
Diabetes	Allergies	Goiter
Leukemia	Bleeding Tendency	Arthritis
Rheumatic Heart	Congenital Heart	Alcoholism
Psychiatric/Emotional Disorders		Osteoporosis

Medical: Please check (x) if you have ever had the following

	Year		Year		Year	
Anemia ( )		DES Exposure ( )		Kidney Disease ( )		TB Skin Test:
Angina ( )		Diabetes ( )		Knocked Unconscious ( )		Positive ( )
Arthritis ( )		Diverticulosis ( )		Malaria ( )		Negative ( )
Asthma ( )		Emphysema ( )		Meningitis ( )		Ulcers ( )
Back Trouble ( )		Gallstones ( )		Pancreatitis ( )		Tonsils ( )
Bladder Infection ( )		Glaucoma ( )		Pleurisy ( )		Gallbladder ( )
Blood Transfusion ( )		Gout ( )		Pneumonia ( )		Ovary ( )
Bowl Polyp ( )		Hay fever ( )		Polio ( )		Prostate ( )
Broken Bones ( )		Heart Attack ( )		Radiation Treatment ( )		Hernia ( )
Bronchitis ( )		Heart Murmur ( )		Rheumatic Fever ( )		Uterus ( )
Cancer ( )		Hemorrhoids ( )		Seizures ( )		Other ( )
Cataract ( )		Hepatitis ( )		Sinusitis ( )		Any other serious listed:
Colo/Sigmoidoscopy ( )		High Blood Pressure ( )		Thyroid Disease ( )		
Appendix ( )		Infectious Mono ( )		Tuberculosis ( )		
Venereal Disease ( )		Jaundice ( )		Exposure to TB ( )		

Continued on next page.

Immunizations:

	Year		Year		Year	
Flu Shot ( )		Tetanus ( )		Pneumovax ( )		Other ( ) Name:

Health Maintenance: Please check (x) if you have ever had the following:

	Year		Year		Year	
Chickenpox ( )		Pap Smear ( )		Hemoccult Cards ( )		PSA ( ) ↓
Mammogram ( )		Colon Cancer Scrn ( )		Prostate Exam ( )		Results:
Cholesterol Test ( ) ↓						
Results:						

List all medications and nutritional/herbal supplements that you currently take:

Personal Habits: (Circle)

Yes No Do you regularly smoke? What?_____ How much per day?_____

Yes No Do you drink tea, coffee or caffeinated soft drinks? What?_____ How many per day?_____

Yes No Do you regularly consume alcohol? What type?_____ How much per day?_____

Yes No Do you exercise regularly? How?_____

Yes No Do you routinely wear a seatbelt?_____

Yes No Do you routinely wear sunscreen?_____

Are you presently taking any of the following?

Yes No	Aspirin, Bufferin, Anacin	Yes No	Tranquilizers
Yes No	Cough Medicine	Yes No	Weight Reducing Pills
Yes No	Laxatives	Yes No	Sleeping Pills
Yes No	Birth Control Pills	Yes No	Water Pills

To be answered by WOMEN only: (Circle)

Yes No Have you ever had breast lumps? When_____

Yes No Do you do monthly self breast exams?

Yes No Have you ever had bleeding between periods? When?_____

Yes No Do you feel bloated and irritable before your periods?

Yes No Do you experience premenstrual syndrome? Explain_____

Yes No Do you experience difficulty or pain with intercourse?_____

Yes No Did you ever have diabetes in pregnancy? How many pregnancies?_____ How many live children?_____ Miscarriages?____

How many cesarean sections?_____

Yes No Have you ever had discharge from your nipples? When?_____

Yes No Are you having regular monthly periods? Date of last_____ Duration_____

Yes No Do you have heavy bleeding with your periods? When?_____

Yes No Do you experience hot flashes or night sweats? When?_____

Yes No Are you now or have you ever taken birth control pills? When?_____

Yes No Do you experience a lack of sex drive?

Any complications of pregnancy?_____

Daily calcium intake:_____ From Diet_____ From Supplements_____

Have you recently had or do you now have any of the following: (Circle)

Yes No	Loss of appetite?	Yes No	Sensitivity to heat or cold?
Yes No	Weight loss? Amount:_____	Yes No	Night Sweats?
Yes No	Weight gain? Amount:_____	Yes No	Hair Loss?
	Vision problems?	Yes No	Depression or nervousness?

Continued on next page.

Have you recently had or do you have any of the following? (Circle)

Yes No	Nausea or vomiting?	Yes No	Crying spells?
Yes No	Easy bruising?	Yes No	Memory loss?

Have you recently had or do you have any of the following? (Circle)

Yes No	Do you frequently have severe headaches? (If yes, answer the following)	Yes No	Do they occur on one side of y
Yes No	Do they cause visual trouble?	Yes No	Do they awaken you at night f
Yes No	Do they feel like a tight band?	Yes No	Does aspirin relieve them?
Yes No	Do you have difficulty seeing?		
Yes No	Do they hurt most in the back of the head and neck?		

Have you recently had or do you have any of the following? (Circle)

Yes No	Have you ever fainted?	Yes No	Loss of hearing?
Yes No	Spells of dizziness?	Yes No	Pains in ears?
Yes No	Loss of strength or feeling in any part of your body?	Yes No	Nosebleeds?
Yes No	Ringing in ears?	Yes No	Do you frequently have nause
Yes No	Do you have inflamed eyes?	Yes No	Do you have persistent hoarse
Yes No	Do you frequently have bleeding gums?		
Yes No	Do you frequently have trouble swallowing?		
Yes No	Have you ever had a convulsion, fit or seizure?		

Have you ever had or recently experienced shortness of breath? If so: (Circle)

Yes No	Doing your usual work?	Yes No	Which causes you to cough?
Yes No	Climbing a flight of stairs or with exertion?	Yes No	Do you have a persistent coug
Yes No	Which awakens you at night?	Yes No	Have you ever coughed blood
Yes No	Accompanied by wheezing?	Yes No	Do you have pain with breathi

Have you recently had or do you now have chest pain or tightness in the chest which begins: (Circle)

Yes No	When exerting yourself?	Yes No	Does it radiate down the arm?
Yes No	When walking against a wind?	Yes No	Does it disappear if you rest?
Yes No	When walking up a hill?	Yes No	Does it occur at rest?
Yes No	After a heavy meal?	Yes No	Do you sleep on more than on
Yes No	When upset or excited?		
Yes No	When walking fast?		
Yes No	Have you experienced palpitations, racing heart or irregular heartbeat?		

If you have chest pain or tightness, please explain_____

Pertaining to bowel habits, have you recently experienced: (Circle)

Yes No	A change in bowel habits?	Now or since when? _____
Yes No	Cramping pain in the abdomen?	Now or since when? _____
Yes No	Alternating diarrhea and constipation?	Now or since when? _____
Yes No	Pain during or after a bowel movement?	Now or since when? _____
Yes No	Mucous in the stool?	Now or since when? _____
Yes No	Blood in the stool?	Now or since when? _____
Yes No	Black stools?	Now or since when? _____
Yes No	Excessive bloating or belching?	Now or since when? _____
Yes No	Do you require use of strong laxatives or enemas?	Now or since when? _____

Have you recently had or currently have: (Circle)

Yes No	Burning or pain when urinating?	Now or since when? _____
Yes No	Loss of control of bladder?	Now or since when? _____
Yes No	Blood or gravel in urine?	Now or since when? _____
Yes No	Dark colored urine?	Now or since when? _____

Continued on next page.

Have you recently had or currently have: (Circle)

Yes No	Trouble starting to urinate?	Now or since when? _____

Yes No Trouble holding the urine or frequent dribbling? Now or since when? _____

Yes No Getting up frequently at night? Now or since when? _____

Yes No Kidney stone passing? Now or since when? _____

Yes No Unusual thirst? Now or since when? _____

Have you recently had or currently have: (Circle)

Yes No Pain in calves of legs when walking? Now or since when? _____

Yes No Pain in calves of legs at rest? Now or since when? _____

Yes No Cramps in legs at night? Now or since when? _____

Yes No Pain in the big toe? Now or since when? _____

Yes No Varicose veins? Now or since when? _____

Yes No Phlebitis or inflamed leg veins? Now or since when? _____

Yes No Swelling in the ankles? Now or since when? _____

Yes No Pain or swelling in the joints? Now or since when? _____

To be answered my MEN only

Have you recently had or currently have: (Circle)

Yes No Loss of sexual activity or drive? For how long? _____

Yes No Treatment for genitals (private parts)?

Yes No Discharge from penis?

Yes No Hernia (rupture)?

Yes No Prostate trouble?

Yes No Painful intercourse?

Describe briefly your present medical symptoms:

Review By: _____ **Date:** _____

List All Surgeries- If you have never had any surgeries then please (circle) not applicable'

Surgery: Date:

When and where was your last mammogram?

When and where was your last colonoscopy?

When and where was the last lab work you had done?

Have you had any imaging done, when and where? (i.e. MRI, CT, ultrasound)

Please list all prescribed medications, dose and how you are taking them.

Any supplements/Herbs/ Over the counter medications