



HISTORY FORMS

DATE _____

AGE _____

Last Name: _____

First Name: _____

MI: _____

Who sent you to us? _____ Who is your primary doctor? _____

Why were you sent to us? _____

MAJOR MEDICAL ILLNESSES: _____

OPERATIONS: (when, type of surgery)

HOSPITALIZATIONS : (when, where, why?)

ALLERGIES: Circle if you have an allergy to any of the following. Please describe reactions

Dye _____ Codeine _____

Foods _____ Tape _____

Penicillin _____ Latex _____

Sulfa _____ Erythromycin _____

Iodine _____ Other _____

PERSONAL HISTORY AND HABITS: Married _____ Single _____ Employed? No Yes

Occupation: _____

Children No Yes How Many ? _____ Living Local ? No Yes

Tobacco use: Present no yes // Past: no yes Date Stopped _____ Pks daily _____

Alcohol-use: Present no yes // Past: no yes Consumption daily ? _____

FAMILY HISTORY : Have any immediate family members had (please check)

Cancer _____ Heart Disease _____ Diabetes _____ Stroke _____ High Blood Pressure _____

Type of Cancer _____

Parents still are living? no yes If No, cause of death? _____

GENERAL INFORMATION

Good general health lately No Yes
Chills or sweats No Yes
Recent weight change No Yes
Fever No Yes
Fatigue No Yes

SKIN INTEGUMENTARY SYSTEM

Psoriasis/Dermatitis No Yes
Rash No Yes

EYES

Cataracts No Yes
Blurred or double vision No Yes
Glaucoma No Yes
Blindness (temp/perm) No Yes
Diabetic Retinopathy No Yes

HEMATOLOGIC

Bruises Easily No Yes
Free Bleeding No Yes
Blood clots in legs No Yes

EARS/NOSE/THROAT

Tonsillectomy No Yes
Chronic sinus problem or rhinitis No Yes
Nosebleeds No Yes
Frequent sore throat No Yes

CARDIOVASCULAR SYSTEM

Chest Pain No Yes
High blood pressure No Yes
Ever have heart failure No Yes
Ever have heart attack No Yes
Palpitations No Yes
Mitral Valve Prolapse No Yes
Shortness of breath rest or stress No Yes
Coronary Artery Disease No Yes
Rheumatic Fever No Yes

VASCULAR

Aneurysm No Yes
Varicose Veins No Yes
Leg pain No Yes
Leg ulcers or non-healing wound No Yes

RESPIRATORY SYSTEM

Frequent pneumonia No Yes
Asthma No Yes
Chronic or frequent coughing No Yes
Shortness of breath No Yes
Blood Clots in lungs No Yes
Emphysema/ Tuberculosis No Yes

NERVOUS SYSTEM

Frequent or recurring headaches No Yes
Light headed or dizziness No Yes
Stroke No Yes
Seizures No Yes
Neuropathy No Yes

PSYCHIATRIC

Anxiety No Yes
Nervousness No Yes
Depression No Yes
Alcohol – Drug Withdrawal No Yes

ENDOCRINE

Thyroid Disease No Yes
Diabetes No Yes
Heat or cold intolerance No Yes
Adrenal Disease No Yes
High Cholesterol No Yes
Pituitary Disease No Yes

MUSCULOSKELETAL SYSTEM

Gout No Yes
Osteoporosis No Yes
Arthritis No Yes
Back Pain No Yes

GASTROINTESTINAL/ DIGESTIVE SYSTEM

Nausea & Vomiting No Yes
Loss of appetite No Yes
Constipation No Yes
Hernia No Yes
Stomach ulcers/gastritis No Yes
Heartburn/GERD No Yes
Hepatitis/Jaundice No Yes
Abdominal pain No Yes
Diarrhea No Yes
Diverticulitis No Yes
Crohn's Disease No Yes
Ulcerative Colitis No Yes
Colon Polyps No Yes

BREAST

Fibrocystic Breast Disease No Yes
Breast Cancer No Yes

URINARY SYSTEM

Prostate Disease or Cancer No Yes
Blood in Urine No Yes
Painful Urination No Yes
Frequent Urinary Tract Infection No Yes
Bladder Problems No Yes
Kidney Stones No Yes
Kidney Failure No Yes