

MEDICAL DATA

Mark an X next to any of the following which you have had or now have.

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eczema | <input type="checkbox"/> Neck Strain |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Flatulence | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Motion Sickness |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Endocrine/ Glandular | <input type="checkbox"/> Neuralgia/Neuritis |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Alcohol Problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Fistul/Fissure | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Parasites/Worms |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Fractures | <input type="checkbox"/> Pain-chest, sciatic, muscular, abdomen |
| <input type="checkbox"/> Baldness | <input type="checkbox"/> German Measles-Rubella | <input type="checkbox"/> Poison Ivy/Oak |
| <input type="checkbox"/> Bladder Infection | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Polyyps |
| <input type="checkbox"/> Bleeding Tendency | <input type="checkbox"/> Gout | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Goiter | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Boils | <input type="checkbox"/> Headaches | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Bowel Condition | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Polio/Paralysis |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cirrhosis (Liver) | <input type="checkbox"/> Hernia | <input type="checkbox"/> Ringworm |
| <input type="checkbox"/> Colds (Recurrent) | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Strep throat |
| <input type="checkbox"/> Colitis/IBS | <input type="checkbox"/> Hepatitis/type ? | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer/type? | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sexual Difficulty |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Congenital Defect | <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Candida/Yeast Infection | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Skin Infections |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Styes |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hypotension | <input type="checkbox"/> Suicide Attempt |
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> High Triglycerides | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Dental Problems | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Salivary Gland Problem |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Impetigo | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Digestion Problems | <input type="checkbox"/> Ingrown Toenails | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dysentary | <input type="checkbox"/> Injuries, serious | <input type="checkbox"/> Toxic Chemical |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Jaundice, Yellowing | <input type="checkbox"/> Poisoning/Exposure |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Kidney/Bladder Disease | <input type="checkbox"/> Tumours |
| <input type="checkbox"/> Diverticulitis/osis | <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Visual Problems |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Veneral Disease |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Voice Problems |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Epstein Barr Virus | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tinnitus: Ringing in ears |
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Mouth Sores | <input type="checkbox"/> Whooping Cough |
| | <input type="checkbox"/> Measles-Rubella | |
| | <input type="checkbox"/> Multiple Sclerosis | |

SOCIAL HISTORY/HABITS

Do you drink coffee, tea or soda? _____ How much? _____

Do you drink alcohol? _____ How much/ How often? _____

Do you smoke or did you ever use tobacco? _____ How much/How often? _____

How many hours do you sleep per night? _____ Do you awaken at night? If so, what time? _____

Have you ever used sleeping pills and/or pain pills? _____ How often? _____

Do you exercise regularly? _____ What type and how often? _____

What do you crave to eat? _____

Have you ever had an eating disorder? _____ If so, what type and how long? _____

Do you have a daily bowel action? _____ If not, how often? _____

Do you feel sleepy or tired after eating? _____

Are you able to fast without symptoms? _____

ALLERGIES:

Are you allergic to medications (Penicillin, Vit. B-12, etc)? _____

Do you have any allergies to animals, foods, drugs, etc. ? If yes, what kind? _____

Do you suffer from any of the following?

_____ Asthma _____ Fatigue _____ Headaches _____ Rashes _____ Muscle ache/pain _____ Itching/Burning skin

_____ Itchy eyes _____ Runny nose _____ Nasal Congestion _____ Arthritis _____ Hives _____ Sneezing spells

Do you have trouble with: _____ Perfume _____ Gasoline fumes _____ Paint/Chemicals
_____ Smoke _____ Others, please specify _____

Do you handle chemicals? _____ Which ones and how long? _____

Do you have trouble with weight? _____ If yes, for you long? _____

Do you now or have you in the past suffered regularly from:

MENTAL/EMOTIONAL:

_____ Poor memory _____ Confusion _____ Poor concentration _____ Nervous Breakdown _____ Frequent crying

_____ Difficulty making decisions _____ Learning disabilities _____ Mental Illness _____ Feelings of desperation

_____ Mood swings _____ Anxiety, fear, nervousness _____ Depression _____ Anger, irritability, aggressiveness

_____ Nervousness with strangers _____ Nail biting _____ Difficulty relaxing _____ Worry a lot _____ Hopeless outlook

_____ Annoyed by little things _____ Dislike criticism _____ Shy or sensitive _____ Scary dreams or thoughts

GASTRO-INTESTINAL;

_____ Constipation _____ Bloating feeling _____ Loose stools _____ Nausea, vomiting _____ Heartburn

_____ Abdominal pain _____ Belching _____ Poor appetite _____ Black stools _____ Indigestion

_____ Pain in Rectum _____ Itching Rectum _____ Blood with stools _____ Always hungry _____ Gas

MUSCULOSKELETAL:

_____ Swollen joints _____ Back or shoulder pain _____ Weakness in arms or legs _____ Painful feet _____ Trembling

_____ Numbness _____ Aching muscles or joints _____ Edema

DERMATOLOGY:

_____ Skin problems _____ Bruise easily _____ Excess sweating _____ Rashes _____ Night sweats

VISION:

_____ Loss of balance _____ Dizzy spells _____ Black outs/fainting _____ See double _____ Blurry vision

_____ Eyesight worsening _____ See halos or lights _____ Eye pain _____ Watering eyes _____ Red eyes

MOUTH/THROAT:

_____ Sore tongue _____ Sore or bleeding gums _____ Hoarse voice _____ Difficulty swallowing

RESPIRATORY

_____ Wheezing or gasping _____ Frequent coughing _____ Coughing up blood

HEALTH HISTORY SUMMARY

Name _____ Age _____ Birthdate _____ Blood Type _____
 Address _____ City _____ State _____ Zip _____
 Phone (home) _____ (work) _____ daytime or eves?
 Occupation _____ full/part-time? Employer _____
 Emergency Contact _____ Phone# _____
 Marital Status: Single Married Divorced Widowed Separated
 How did you hear of this office? _____
 Email address: _____

CURRENT HEALTH PROBLEMS

LENGTH OF TIME

- | | | |
|----|--|--|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |

Have you consulted another Doctor about these problems? _____
 If yes, Doctor's name: _____

PREVIOUS ILLNESSES/HOSPITALIZATIONS/SURGERIES YEAR

LIST ANY MEDICATION, SUPPLEMENT OR HERB YOU ARE TAKING W/ DOSAGE

- | | | |
|----|--|--|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |

TESTS

Indicate date below of test.

_____ Complete Physical Exam	_____ CAT/MRI Scan	_____ Sigmoidoscopy
_____ X-ray (chest, kidney, GI, Colon, etc)	_____ Prostate	_____ Mammography
_____ Pap smear	_____ TB Test	_____ Cholesterol
_____ HIV/STD		_____ Other

HEALTH HISTORY

At what time of the day or night are your symptoms worse? _____
 Do you prefer to be inside/outside? _____ Do weather changes affect you? _____
 If yes, how? _____
 Do you sleep well? Yes No If no, elaborate. _____
 What is your energy level? (Worst-Best) 1 2 3 4 5 6 7 8 9 10
 What makes your symptoms better? _____
 Worse? _____
 What was the most significant medical or emotional occurrence in your life? _____
 On a scale of 1-10, what do you rate your current stress level? _____ What are the stressors in your life? _____