PATIENT HISTORY FORM

Date: ______/________/________

NAME: ______________________________ (Last / First / M. I.) Birthdate: _____/______/_____

Age:__________ Biological Sex: ☐ F ☐ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names & specialty of other practitioners you have seen for this problem:

PERSONAL HISTORY

What is your current or past occupation?

Are you currently working? : ☐ Yes ☐ No

Do you receive disability or SSI?
☐ Yes ☐ No

Do you have a regular exercise routine? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Cancer (type) ________________
- ☐ Psoriasis
- ☐ Angina (chest pain)
- ☐ Pacemaker
- ☐ Heart problems
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ COPD
- ☐ Asthma
- ☐ Arthritis (type) __________
- ☐ Stroke (year) __________
- ☐ TIA (year) __________
- ☐ Seizures
- ☐ Osteoporosis
- ☐ Kidney disease
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Hepatitis (type) ________
- ☐ GERD (Gastric Reflux)
- ☐ Parkinson Disease
- ☐ Multiple Sclerosis
- ☐ HIV/AIDS
- ☐ Fibromyalgia

Other medical conditions (please list):

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ☐ Recent weight gain; how much____
- ☐ Recent weight loss: how much____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Tremors

MUSCLE/JOINTS/BONES
- ☐ Numbness
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Muscle spasm
- ☐ Hand tremors
- ☐ Joint swelling

Where?

EARS
- ☐ Ringing in ears
- ☐ Loss of hearing
- ☐ Feeling of fullness

EYES
- ☐ Pain
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Floaters or "squiggles"

THROAT
- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain or numbness in jaw

HEART AND LUNGS
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Swollen legs or feet
- ☐ Cough

NERVOUS SYSTEM
- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Slurred speech
- ☐ Memory loss
- ☐ Brief inability to move limbs
- ☐ Numbness or tingling

Where?

STOMACH AND INTESTINES
- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Frequent constipation
- ☐ Persistent diarrhea
- ☐ Black stools
- ☐ Painful defecation

SKIN
- ☐ Redness
- ☐ Rash
- ☐ Nodules/bumps
- ☐ Color changes of hands or feet

BLOOD
- ☐ Anemia
- ☐ Clots

KIDNEY/URINE/BLADDER
- ☐ Frequent or painful urination
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Leaking urine
  - ☐ Laughing/coughing/sneezing
  - ☐ Random leaking

Women Only:
- ☐ Pain during intercourse
- ☐ Irregular periods
- ☐ Bleeding between periods

PSYCHIATRIC
- ☐ Depression
- ☐ Excessive worries
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Difficulties with sexual arousal
- ☐ Poor appetite
- ☐ Food cravings
- ☐ Frequent crying
- ☐ Sensitivity
- ☐ Thoughts of suicide / attempts
- ☐ Stress
- ☐ Irritability
- ☐ Poor concentration
- ☐ Racing thoughts
- ☐ Hallucinations
- ☐ Rapid speech
- ☐ Guilty thoughts
- ☐ Paranoia
- ☐ Mood swings
- ☐ Anxiety
- ☐ Risky behavior

OTHER PROBLEMS:

PAST SURGICAL HISTORY

Please list any surgeries you have had.	Month of surgery	Year of Surgery

CURRENT MEDICATIONS (if you have a list already, please give it to personnel for photocopy)

Drug allergies: ☐ No ☐ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		