

Medical History Template

The purpose of this form is to understand your past and present medical history.

Primary Complaint

Aggravating and Relieving Factors

Secondary Complaint

Aggravating & Relieving Factors

Other Complaints

Tell Us About Your Past Medical History

Please Mark The Check Box If You Previously Suffered From These Conditions.

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Bird Flu |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Diabetes Type 2 |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Goiter |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Hypertension | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Hyper Thyroid | <input type="checkbox"/> Herpes Simplex | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Hypo Thyroid | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Mono | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Mumps | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Polio | <input type="checkbox"/> PTSD | <input type="checkbox"/> Physical Abuse |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Reynaud's Disease |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> STD's | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Uterine Fibroids |

Addictions

Cancer? What Type?

Hospitalization, Operations and Significant Traumas

Your Family's Medical History

Addictions

Cancer

Fatty Liver

Heart Disease

Strokes

Asthma

Diabetes

High Blood Pressure

Mental Disease

Thyroid Disease

Tell Us About Your Lifestyle

Diet

Exercise

Mark The Ones That Describe You

☐ Sleep After Midnight

☐ Drink Coffee Often

☐ Drink Soda Often

☐ Smoke Tobacco Daily

☐ Smoke Marijuana Often

☐ Drink Alcohol Often

Recreational Drugs?

Stress Level

Current State of Health

My Body Temperature Feels?

☐ Hot

☐ Cold

☐ Normal

General Symptoms

☐ Edema

☐ Bruise Easy

☐ Chills

☐ Fever

☐ Body Aches

☐ Aversion To Wind

☐ Aversion To Cold

☐ Aversion To Heat

☐ Strong Thirst

☐ Low Thirst

☐ Poor Appetite

☐ Night Sweats

☐ Insomnia

☐ Fatigue

☐ Nasal Congestion

☐ Foggy Headed

☐ Dizziness

☐ Short Of Breath

Head, Eyes, Ears, Nose & Throat Symptoms

- | | | |
|--|---|---|
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Red Eyes | <input type="checkbox"/> Blurry Vision |
| <input type="checkbox"/> Poor Night Vision | <input type="checkbox"/> Floaters | <input type="checkbox"/> Eye Strain |
| <input type="checkbox"/> Difficult to Focus | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glasses/Contacts |
| <input type="checkbox"/> Ear Ringing: High Pitch | <input type="checkbox"/> Ear Ringing: Low Pitch | <input type="checkbox"/> Poor Hearing |
| <input type="checkbox"/> Block Sinus | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Dental Problems |
| <input type="checkbox"/> Hoarse Voice | <input type="checkbox"/> Headaches | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Mouth Sores/Ulcers | <input type="checkbox"/> Migraines | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Ear Aches |
| <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Plum Pit Feeling in Throat | <input type="checkbox"/> Excess Saliva |

Cardiovascular Symptoms, Signs & Diseases

- | | | |
|--|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Heart Beating Fast | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Cold Hand/Feet |
| <input type="checkbox"/> Swelling of Hand/Feet | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Left Arm Pain | <input type="checkbox"/> Varicose Veins |

Respiratory Signs & Symptoms

- | | | |
|---|--|---|
| <input type="checkbox"/> Dry Cough | <input type="checkbox"/> Wet Cough | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Phlegmy | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Pain When Breathing Deep | <input type="checkbox"/> Short of Breath | <input type="checkbox"/> Chest Tightness |
| <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Labored Breathing | <input type="checkbox"/> Breath Feels Hot |

GastroIntestinal

- | | | |
|--|---|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Bloating | <input type="checkbox"/> Abdominal Pain/Cramp |
| <input type="checkbox"/> Hiccup | <input type="checkbox"/> Acid Regurgitation | <input type="checkbox"/> Belching |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Rectal Pain |
| <input type="checkbox"/> Anal Fissures | <input type="checkbox"/> Itchy Anus | <input type="checkbox"/> Hemorrhoids |

Genitourinary

- | | | |
|---|--|--|
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Wakes Up To Urinate | <input type="checkbox"/> Pain During Urination |
| <input type="checkbox"/> Incomplete Urination | <input type="checkbox"/> Decrease Flow | <input type="checkbox"/> Decrease Stream Power |
| <input type="checkbox"/> Unable to Hold Urine | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Smelly Urine | <input type="checkbox"/> Dark Yellow Urine | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Wet Dreams | <input type="checkbox"/> Impotence (Men) | <input type="checkbox"/> Enlarged Prostate (Men) |
| <input type="checkbox"/> Low Semen Volume (Men) | <input type="checkbox"/> Premature Ejaculation | <input type="checkbox"/> Genital Itching |
| <input type="checkbox"/> Genital Sores | <input type="checkbox"/> High Libido | <input type="checkbox"/> Low Libido |

Gynecological & Obstetrics (Women Only)

- ☐ Currently Pregnant
- ☐ No Menstrual Cycle
- ☐ PCOS
- ☐ Uterine Fibroids
- ☐ Irregular Menses
- ☐ Endometriosis
- ☐ PMS
- ☐ Vaginal Sores
- ☐ Menstrual Clots
- ☐ Ovarian Cysts
- ☐ PID
- ☐ Frequent Yeast Infections

Gynecological

Last Menstrual Period



Date of Last PAP



Age Menses Started

Number of Days Between Periods?

How Many Days Do You Bleed (During Period)?

Menstrual Blood Clots

Color of Menstrual Blood

What is Your Flow Like?

Irregular Menses

Mid-Cycle Bleeding?

Menopause

Birth Control

Breast Lumps

Vaginal Discharge

Obstetrics

How many months pregnant?

Previous Live Births?

Premature Births?

Any Miscarriages?

Previous Abortions?

IVF

Musculoskeletal

What Areas Are Painful?

- | | | |
|--|---|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Neck | <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Middle Back | <input type="checkbox"/> Lower Back |
| <input type="checkbox"/> Ribs | <input type="checkbox"/> Wrist | <input type="checkbox"/> Hip |
| <input type="checkbox"/> Upper Leg | <input type="checkbox"/> Side of Leg | <input type="checkbox"/> Lower Leg |
| <input type="checkbox"/> Knee | <input type="checkbox"/> Ankle | <input type="checkbox"/> Foot |
| <input type="checkbox"/> Fingers | <input type="checkbox"/> Toes | <input type="checkbox"/> Groin |
| <input type="checkbox"/> General Muscle Weakness | <input type="checkbox"/> Muscle Tightness | <input type="checkbox"/> Full Body Aches/Pain |

Neuropsychological

Do You Feel Numbness?

- | | | |
|---------------------------------|-----------------------------------|-------------------------------|
| <input type="checkbox"/> Face | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Arms |
| <input type="checkbox"/> Wrists | <input type="checkbox"/> Fingers | <input type="checkbox"/> Toes |
| <input type="checkbox"/> Legs | <input type="checkbox"/> Ankles | <input type="checkbox"/> Foot |

Frequent Emotions

- | | | |
|-------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Fear | <input type="checkbox"/> Grief | <input type="checkbox"/> Worried |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Suicidal | <input type="checkbox"/> Irritable | <input type="checkbox"/> Manic |

General Symptoms

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Lack of Coordination |
| <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Tremors | <input type="checkbox"/> Panic Attacks |

Paralysis

Other Neurological Issues

Anything We Missed or You Want To Tell Us?