Patient Case History

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Name _____**Date** _____**Chart #** _____

Have you ever been diagnosed with *any* medical conditions? *YES OR NO* **If *yes, c*ircle *ALL* that apply**

Alcoholism	Epilepsy	Osteoporosis
Anemia	Hepatitis	Pacemaker
Asthma	Hernia	Parkinson's
Autoimmune issues	Herniated disc	Pneumonia
Bleeding disorder	High Blood Pressure	Polio
Bronchitis	High cholesterol	Prostate problems
Chemical Dependency	HIV/AIDS	Rheumatoid Arthritis
Depression	Kidney disease	Stroke
Diabetes	Migraine headache	Thyroid problems
Emphysema	Multiple Sclerosis	Tumor/cyst

Cancer (***list types/locations/dates***) _____
***Other* medical condition** (*not listed above*) _____

Are you *currently* taking medications (*including vitamins and organics)? YES or NO* **If *yes,* please list:**

1._____ dosage _____ x per day____ 4. _____ dosage _____x per day _____
2._____ dosage _____ x per day____ 5. _____ dosage _____ x per day_____
3._____ dosage _____ x per day____ 6. _____ dosage _____ x per day_____

Have you had surgery? *YES or NO* If *yes*, please list type(s) and date(s)

_____

***Any* accidents/injuries? *YES or NO* If *yes*, please list, include dates (MVA, broken bones, bad falls, etc.)**

_____

Do you have allergies (*medications, foods, environmental*)? *YES or NO* **If *yes,* please list type(s)**

_____

Any* changes with bodily function? *YES or NO **If *yes*, circle *ALL* that apply**

change in vision	difficulty swallowing	difficulty breathing	change in bowel movement
incontinence	dizziness	loss of balance	motor weakness

How do you use your spare time? _____
Are you a smoker? *YES or NO* If *yes*, how long? _____**past smoker?** _____**quit date**_____
Are you on a special diet? *YES or NO* If *yes,* type of diet_____
Do you have a regular exercise program? *YES or NO* If *yes*, type of exercise _____

List your family medical history (*example: mother-diabetes, heart disease*)

Mother _____ **Father**_____
Brother(s)_____ **Sister(s)** _____
Maternal Grandmother/Grandfather _____
Paternal Grandmother/Grandfather _____

Date of last:

_____ physical exam _____ bone density _____ blood work _____ PSA testing (men prostate)

My signature below acknowledges this is my complete medical history.
Patient/Guardian Signature_____**Date** _____

Intake