MEDICAL HISTORY

PLEASE FILL IN WITH BLACK OR BLUE INK

NAME _____ DOB _____ AGE _____ PT# _____

CHIEF COMPLAINT _____ DATE OF APPOINTMENT _____

REFERRING CLINIC OR DOCTOR (IF ANY): _____

CLINIC ADDRESS _____ CLINIC PHONE _____

SYSTEM REVIEW

UNDERLINE OR CIRCLE ANY SYMPTOMS YOU HAVE EXPERIENCED IN THE LAST YEAR

NOSE: BLOCKED (MOUTH BREATHER) BLOODY ITCHY LOSS OF SMELL PAIN POLYPS PRESSURE RUNNY SINUS HEADACHES SINUS INFECTIONS SNEEZING STUFFY

EARS: BLOCKED (IMPAIRED HEARING) CONGESTION DIZZY DRAINING INFECTION ITCHY PAIN TINNITUS (RINGING) TUBES (WHEN_____)

MOUTH: ADENOIDS OUT (WHEN_____) CANKERS DRY GRINDING TEETH ITCHY PALATE SNORING THRUSH TONSILS OUT (WHEN_____)

THROAT: HOARSENESS ITCHING POST NASAL DRAINAGE SORE THROAT TMJ SYNDROME

LUNGS: BRONCHITIS BURNING CHEST PAIN DIFFICULTY BREATHING DRY COUGH PNEUMONIA PRODUCTIVE COUGH SHORTNESS OF BREATH TIGHTNESS WHEEZING

EYES: BURNING DRY IRRITATION ITCHY PAIN RED SWOLLEN WATERY

SKIN: ACNE DRY ECZEMA HIVES (WELTS) ITCHING RASH REDNESS SWELLING

GENERAL: DECREASED ENERGY FATIGUE FEVER FREQUENT COLDS HYPERTENSION INSOMNIA JOINT PAINS NIGHT SWEATS

GI: ABDOMINAL CRAMPS/PAIN CONSTIPATION DIARRHEA DIFFICULTY SWALLOWING HEARTBURN NAUSEA RECTAL ITCHING REFLUX VOMITTING

ENDOCRINE: COLD INTOLERANCE DIABETES HEAT INTOLERANCE INSULIN RESISTANCE SLEEP DISTURBANCE WEIGHT GAIN WEIGHT LOSS

MEDICAL HISTORY

HOW LONG HAVE YOU HAD TROUBLE? _____

CIRCLE THE MONTHS YOU HAVE SYMPTOMS:

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

IS THERE A HISTORY OF CONTACT RASHES? SOAPS LOTIONS FABRICS SHRUBBERY GRASS WEEDS LATEX ADHESIVES METALS OTHER_____

HAVE YOU BEEN SKIN TESTED BEFORE? NO_____ YES_____

WHERE? _____ WHEN? _____

IF ON ALLERGY INJECTIONS:

DATE, DOSE AND DILUTION OF LAST INJECTION _____

ANY REACTIONS? _____

HOW OFTEN DO YOU GET YOUR INJECTIONS? _____

MAINTENANCE DOSE & DILUTION _____

WHO GIVES YOUR INJECTIONS? _____

Over →

Flu Shot No ___ Yes___ Date_____ Pneumo No ___ Yes___ Date_____

ALLERGIES **Vaccinations Up To Date_____**

ARE YOU ALLERGIC TO ANY FOOD, MEDICINES, OR INSECT STINGS _____

FAMILY HISTORY (BROTHERS, SISTERS, SONS, DAUGHTERS) WHO HAVE:

ALLERGIES _____ ASTHMA _____

ECZEMA _____ HIVES _____

SOCIAL HISTORY

WHERE WERE YOU BORN AND RAISED _____

HOW LONG AGO DID YOU MOVE HERE_____FROM WHERE?_____

WHAT DO YOU SUSPECT YOU ARE ALLERGIC TO?

TREES GRASS WEEDS DUST MOLDS ANIMALS FOODS UNKNOWN

HOME

FLOORING: CARPET TILE WOOD LINOLEUM CEMENT LAMINATE ROCK

HEATING SOURCE: GAS ELECTRIC PROPANE WOODSTOVE HEAT PUMP FIREPLACE OIL

HEATING TYPE: FURNACE, CEILING CABLE, BASEBOARD, CADET, FIRE PLACE, IN FLOOR , WOOD STOVE

MATTRESS: INNERSPRING FOAM TEMPUR-PEDIC WATERBED SLEEPNUMBER LATEX FUTON

PILLOWS: DACRON(POLYESTER) FOAM DOWN(FEATHER) HYPOALLERGENIC BAMBOO BUCKWHEAT GEL

HOW OLD IS YOUR HOUSE _____ WHERE IS IT LOCATED _____

NUMBER OF INSIDE PETS _____ WHAT KIND? _____ WHERE DO THEY SLEEP? _____

NUMBER OF OUTSIDE ANIMALS _____ WHAT KIND? _____

NUMBER OF HOUSE PLANTS _____

WHAT KIND OF TREES ARE IN YOUR YARD AND CLOSE BY _____

WHERE DOES THE PATIENT (IF PATIENT IS A CHILD, FATHER) WORK _____

JOB DESCRIPTION _____

WHERE DOES THE SPOUSE/MOTHER WORK _____ JOB DESCRIPTION _____

WHAT ARE YOUR HOBBIES _____

DO YOU OR HAVE YOU EVER SMOKED _____ HOW MUCH AND HOW LONG _____

DOES ANYONE IN YOUR FAMILY SMOKE _____ CHEW _____

WHO/HOW MUCH _____

MEDICATIONS YOU HAVE TRIED AND RESULTS _____

_____

_____

WHAT HAVE YOU TAKEN IN THE LAST 24 HOURS _____

WHAT HAVE YOU TAKEN IN THE LAST WEEK _____

VITALS (TO BE FILLED OUT BY NURSE)

BP _____/_____ PULSE _____ R.R. _____ ACT ____ O_2 _____ HT _____ WT_____ TEMP _____