



**Medical History**  
**PLEASE COMPLETE ALL PAGES**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ DOB: \_\_\_\_\_

Please be as specific as possible as this form will give us a better understanding of your medical concerns and conditions. If you are uncomfortable with any questions, do not answer them. Please contact family members if you need assistance in completing the Family History section. You may attach additional pages as necessary.

**THANK YOU!**

How would you rate your current health?  Excellent  Good  Fair  Poor

Current age: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Ethnicity: \_\_\_\_\_  
Waist measurement: \_\_\_\_\_ Date of last Physical Exam: \_\_\_\_\_

**Medications: Prescription and Non-prescription medications, vitamins, home remedies, birth control pills, herbs:**

Medication:	Dose (eg. Mg/pill)	How many times/day	When started	Why using

Allergies or Adverse Reactions to Medicines: \_\_\_\_\_

**Date of most recent screening for the following:**

Cholesterol \_\_\_\_\_ Chest X-Ray \_\_\_\_\_ EKG \_\_\_\_\_  
Spirometry \_\_\_\_\_ Bone Density \_\_\_\_\_  
Any other VASCULAR TEST \_\_\_\_\_

**Personal Medical History:**

Please indicate whether you have had any of the following medical problems (with dates):

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart Disease _____                  | <input type="checkbox"/> Cancer (Malignancy) _____                             | <input type="checkbox"/> Pre-diabetes _____            |
| <input type="checkbox"/> Bleeding/Clotting Problems _____     | <input type="checkbox"/> Diabetes <i>specify type</i> _____                    | <input type="checkbox"/> Chronic Dental Problems _____ |
| <input type="checkbox"/> Alcoholism <i>specify type</i> _____ | <input type="checkbox"/> Thyroid Problems _____                                | <input type="checkbox"/> Osteoporosis _____            |
| <input type="checkbox"/> Rheumatoid Arthritis _____           | <input type="checkbox"/> Depression/Suicide Attempts _____                     | <input type="checkbox"/> Autoimmune Disorder _____     |
| <input type="checkbox"/> Gout _____                           | <input type="checkbox"/> Unexplained Nerve Problems <i>specific type</i> _____ |  |
| <input type="checkbox"/> Aortic Aneurysm _____                | <input type="checkbox"/> Lupus _____   | <input type="checkbox"/> H. Pylori Infection _____     |
| <input type="checkbox"/> High Blood Pressure _____            | <input type="checkbox"/> Psoriasis _____                                       | <input type="checkbox"/> Other _____                   |
| <input type="checkbox"/> Blood Transfusion _____              | <input type="checkbox"/> Migraine Headaches _____                              |  |
| <input type="checkbox"/> Polycystic Ovaries _____             | <input type="checkbox"/> With Aura <input type="checkbox"/> Without Aura       |  |
| <input type="checkbox"/> High Cholesterol _____               | <input type="checkbox"/> Fatty Liver _____                                     |  |
| <input type="checkbox"/> Poor Blood Flow to Extremities _____ |  |  |

**Have you ever had the following procedures? If so, please list the dates:**

Coronary Artery Bypass Surgery \_\_\_\_\_ Angioplasty or Stent \_\_\_\_\_ Angiogram \_\_\_\_\_

**Have you ever been hospitalized for illness? Yes No If so, list when and reason:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



**Surgical History:** Please list all other operations (with dates)

\_\_\_\_\_  
\_\_\_\_\_

**Social History:**

**Tobacco use:** Cigarettes:  Never  Quit: Date: \_\_\_\_\_ Pack/Years \_\_\_\_\_ Current Smoker.

Pack/day \_\_\_\_\_

Other Tobacco:  Pipe  Cigar  Chew # of years \_\_\_\_\_

Are you interested in quitting?  No  Yes Second-hand smoke exposure?  No  Yes

**Alcohol use:** Do you drink alcohol?  No  Yes # of drinks/week \_\_\_\_\_

Is alcohol a concern for you or others?  No  Yes

**Sexual History:**

*Male:* Do you have problems with erections?  No  Yes Date of Onset: \_\_\_\_\_

*Female:* Birth control method: \_\_\_\_\_ None needed \_\_\_\_\_

#of pregnancies \_\_\_\_\_ #of deliveries \_\_\_\_\_ #of miscarriages \_\_\_\_\_

Problems with pregnancy or deliveries? \_\_\_\_\_ Osteoporosis \_\_\_\_\_ Osteopenia \_\_\_\_\_

Any history of gestational diabetes?  No  Yes Eclampsia?  No  Yes

Children weighing over 10 lbs. at birth?  No  Yes

1<sup>st</sup> day of most recent period: \_\_\_\_\_ Age at 1<sup>st</sup> period: \_\_\_\_\_ Frequency \_\_\_\_\_ Length of each: \_\_\_\_\_

**Other Concerns**

**Caffeine Intake:**  None  Coffee/Tea \_\_\_\_\_ cups/day  Sodas \_\_\_\_\_ day  Chocolate \_\_\_\_\_ oz/day

**Weight:** Are you satisfied with your weight?  No  Yes

**Diet:** How do you rate your diet?  Good  Fair  Poor

Do you take supplements?  No  Yes (if so, what kind?) \_\_\_\_\_

Do you drink 4 large glasses of milk daily or take Calcium supplements?  No  Yes

**Exercise:** Do you exercise regularly?  No  Yes

What kind of exercise? \_\_\_\_\_

How long? Minutes? \_\_\_\_\_

How often? \_\_\_\_\_

If you do not exercise, why? \_\_\_\_\_



**Socioeconomics:** Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Years of Education/Highest Degree: \_\_\_\_\_ Marital Status:  S  M  D  W  
Spouse/partner's name: \_\_\_\_\_ Who lives at home with you? \_\_\_\_\_  
Number of children: \_\_\_\_\_ Ages: \_\_\_\_\_

**Stress:** How would you classify the stress at work?  minimal  medium  high  
How would you classify the stress at home?  minimal  medium  high  
Do you feel anxious, angry, irritated or rushed?  No  Yes

**Nutrition:** How many daily servings of the following to you have?  
\_\_\_\_\_ Whole grains \_\_\_\_\_ Fruits \_\_\_\_\_ Vegetables

How many times in one week do you consume the following items?  
\_\_\_\_\_ Eggs \_\_\_\_\_ Fish \_\_\_\_\_ Chicken/Turkey \_\_\_\_\_ Red meat \_\_\_\_\_ Butter \_\_\_\_\_ Margarine  
\_\_\_\_\_ Other high fat dairy products \_\_\_\_\_ Other low fat dairy products \_\_\_\_\_ Fried foods  
\_\_\_\_\_ High fat snacks \_\_\_\_\_ What type of cooking oil do you use? \_\_\_\_\_

**Review of symptoms:** Please check (✓) any current problems you have on the list below:

**Constitutional:**

- Fever/Chills/Sweats
- Inability to stand heat
- Inability to stand cold
- Change in skin texture
- Change in hair texture
- Dry skin
- Brittle Nails
- Unexplained weight loss/gain
- Change in energy/weakness
- Excessive thirst or urination

**Respiratory:**

- Cough/Wheeze  Difficultly breathing
- Snore

**Eyes:**

- Change in vision

**Ears/Nose/Throat/Mouth:**

- Difficulty hearing/ringing in ears  
 Problems with teeth/ gums  
 Hay Fever/Allergies  
 Growth in throat/neck

**Cardiovascular:**

- Chest pain/discomfort  
 Palpitations

**Chest: (Breast)**

- Breast lump/nipple discharge

**Skin:**

- Rash/mole change  
 Acanthosis nigricans

**Genitourinary:**

- Unusual frequency of urination

**Sexual:**

- Problems with erectile function

**Gastrointestinal:**

- Abdominal pain  
 Diarrhea/constipation  
 Blood in bowel movement  
 Heartburn  
 Nausea/vomiting

**Neurological:**

- Headaches  
 Loss of coordination

**Psychiatric:**

- Problems with sleep  
 Depression  
 Panic attacks  
 Mania

**Blood/Lymphatic:**

- Easy bruising/bleeding  
 Unexplained lumps

**Any Other Symptoms?** If yes, please explain: \_\_\_\_\_

\_\_\_\_\_



## Family History

**Please indicate the current status of your immediate family members**

	<u>Alive</u>	<u>Deceased</u>	<u>Age (At present or at death)</u>	<u>Comments/Cause of death</u>
Mother's Mother	_____	_____	_____	_____
Mother's Father	_____	_____	_____	_____
Father's Mother	_____	_____	_____	_____
Father's Father	_____	_____	_____	_____
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Daughter	_____	_____	_____	_____
Daughter	_____	_____	_____	_____
Daughter	_____	_____	_____	_____
Son	_____	_____	_____	_____
Son	_____	_____	_____	_____
Son	_____	_____	_____	_____

**Please use this space to add any additional family members:**

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



## Family History

Please indicate with a (✓) family members who have had any of the following:

Medical Condition	Mom	Dad	Sister	Brother	Diagnosed	Son	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sis.	Mom's Bro.	Dad's Sis	Dad's Bro
Alcoholism														
Anemia														
Aortic aneurysm														
Alzheimer's														
Arthritis														
Asthma														
Autoimmune disorder														
Bleeding Problems														
Carotid Artery disease														
Cancer														
Gout														
Heart Attack														
Depression														
Diabetes-Type 1 (Childhood onset)														
Diabetes-Type 2 (Adulthood onset)														
Other genetic disease														
High Cholesterol (Hyperlipidemia)														



Medical Condition	Mom	Dad	Sister	Brother	Dad's Mother	Son	Mom's Mother	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sis.	Mom's Bro.	Dad's Sis	Dad's Bro
High blood pressure (Hypertension)														
Immunosuppressive Disorders														
Kidney disease														
Osteoporosis														
Peripheral vascular disease														
Epilepsy (seizure disorder)														
Stroke														
Substance Abuse														
Thyroid disorder														
Smoking														
Sleep Apnea														