5 HEALTH HISTORY

Check symptoms you now have or have had in the last year.

- ☐ Depression
- ☐ Difficulty in focusing
- ☐ Dizziness
- ☐ Easily startled
- ☐ Excessive worry
- ☐ Excessive anger
- ☐ Excessive fear
- ☐ Fatigue/tiredness
- ☐ Headaches
- ☐ Loss of sleep/poor sleep
- ☐ Loss or gain of weight
- ☐ Nervousness/irritability
- ☐ Overwhelmed by life

MUSCLE/JOINT/BONES

- ☐ Tremors ☐ Cramps
- ☐ Swollen joints

Pain, weakness, numbness in

- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Other_____

GASTROINTESTINAL

- ☐ Belching, gas or bloating
- ☐ Colon trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Distention of abdomen
- ☐ Excessive hunger
- ☐ Gall bladder trouble
- ☐ Hemorrhoids (piles)
- ☐ Indigestion
- ☐ Nausea
- ☐ Pain over stomach
- ☐ Poor appetite
- ☐ Vomiting

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Hardening of arteries
- ☐ High or low blood pressure
- ☐ Pain over heart
- ☐ Poor circulation
- ☐ Previous heart attack
- ☐ Rapid/irregular heart beat
- ☐ Swelling of ankles

EENT/RESPIRATORY

- ☐ Asthma/wheezing
- ☐ Blurred or failing vision
- ☐ Difficulty breathing
- ☐ Earache
- ☐ En larged glands
- ☐ Eye pain
- ☐ Frequent colds
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Gum trouble
- ☐ Nose bleeds
- ☐ Loss of hearing
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems

SKIN

- ☐ Boils
- ☐ Bruise easily
- ☐ Dry skin
- ☐ Itching/rash
- ☐ Sensitive skin
- ☐ Sore won't heal
- ☐ Sweats

GENITO/URINARY

- ☐ Blood/pus in urine
- ☐ Frequent urination
- ☐ Inability to control urine
- ☐ Kidney infection/stones
- ☐ Lowered libido

FOR MEN ONLY

- ☐ Erection difficulties
- ☐ Penis discharge
- ☐ Prostate trouble

FOR WOMEN ONLY

- ☐ Bleeding between periods
- ☐ Clots in menses
- ☐ Excessive menstrual flow
- ☐ Extreme menstrual pain
- ☐ Irregular cycle
- ☐ Menopausal symptoms
- ☐ PMS
- ☐ Previous miscarriage
- ☐ Scanty menstrual flow

Could you be pregnant?_____

Check conditions you have or have had in the past.

- ☐ AIDS
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ HIV positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcers

How long has it been since you have had a complete medical exam?

_____

6 LIFESTYLE

Check which substances you use and describe how much you use.

- ☐ Caffeine _____
- ☐ Drugs _____
- ☐ Alcohol _____
- ☐ Tobacco _____
- ☐ Sugar _____

Check if your work or lifestyle exposes you to these.

- ☐ Stress
- ☐ Insufficient sleep
- ☐ Very long working hours
- ☐ Long commuting times
- ☐ Heavy lifting or hazardous substances
- ☐ Other_____

7 SIGNATURE

The information on this form is correct to the best of my knowledge. I understand that my protected health information will be used and disclosed consistent with the policies in this office's Notice of Privacy Practices.

Signature_____ Date_____