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CONFIDENTIAL PATIENT HISTORY

I Please **circle(O)** the conditions you *currently have*, and **underline** the conditions you *have had in the past*.

GENERAL

HEADACHE
FEVER
CHILLS
NIGHT SWEATS
FAINTING
DIZZINESS
CONVULSIONS
LOSS OF SLEEP
FATIGUE
NERVOUSNESS
LOSS OF WEIGHT
NUMBNESS/PAIN
IN ARMS/LEGS OR
HANDS/FEET
MENTAL DISORDER
ALCOHOLISM
CANCER
POLIO
MUMPS
GOUT
DIABETES
H.I.V./A.I.D.S.

FOR WOMEN ONLY

PAINFUL PERIODS
EXCESSIVE FLOW
IRREGULAR CYCLE
HOT FLASHES
CRAMPS OR BACKACHE
MISCARRAIGE
VAGINAL DISCHARGE
PRESENTLY PREGNANT
WHAT TRIMESTER _____

GASTRO-INTESTINAL

POOR APPETITIE
POOR DIGESTION
EXCESSIVE HUNGER
BELCHING OR GAS
NAUSEA/ VOMITTING
VOMITTING BLOOD
PAIN OVER STOMACH
CONSTIPATION
DIARRHEA
COLON TROUBLE
HEMORRHOIDS
LIVER TROUBLE
JAUNDICE
GALL BLADDER
HEPATITIS
ULCERS
APPENDICITIS

CARDIOVASCULAR

RAPID HEARTBEAT
SLOW HEARTBEAT
HIGH BLOOD PRESSURE
LOW BLOOD PRESSURE
PAIN OVER HEART
PREVIOUS HEART TROUBLE
SWELLING OF ANKLES
POOR CIRCULATION
VARICOSE VEINS
STROKE
ARTERIOSCLEROSIS
HEART DISEASE
STROKE
ANEMIA

EYE/EAR/NOSE/THROAT

POOR VISION
CROSSED EYES
PAIN IN EYES
DEAFNESS
EARACHES
EAR RINGING
EAR DISCHARGE
NASAL OBSTRUCTION
NOSE BLEEDS
SORE THROAT
HOARSENESS
HAY FEVER
ASTHMA
FREQUENT COLDS
ENLARGED THYROID
TONSILITIS
SINUS TROUBLE
GOITER

MUSCLE & JOINTS

WEAKNESS
Twitching
STIFF NECK
BACK ACHE
SWOLLEN JOINTS
TREMORS
FOOT TROUBLE
PAINFUL TAILBONE
PAIN BETWEEN SHOULDERS
HERNIA
SPINAL CURVATURE
ARTHRITIS
"WHIP-LASH" INJURY

RESPIRATORY

CHRONIC COUGH
SPITTING BLOOD
SPITTING PHLEGM
CHEST PAIN
TROUBLE BREATHING
PNEUMONIA
WHEEZING
TUBERCULOSIS

GENITO-URINARY

FREQUENT URINATION
PAINFUL URINATION
BLOOD IN URINE
KIDNEY INFECTION
BED WETTING
URINE CONTROL (INABILITY)
PROSTATE TROUBLE
VENEREAL DISEASE

SKIN OR ALLERGIES

SKIN ERUPTIONS
ITCHING
BRUISE EASILY
DRYNESS
SENSITIVE SKIN
HIVES
ALLERGIES
ECZEMA
MEASLES
CHICKEN POX
SMALL POX

II Give **exact dates** if possible. When was your last:

Physical Examination _____

Blood Test _____

Urine Test _____

Chest X-ray _____

Spinal X-ray _____

Dental X-ray _____

FEMALES ONLY

Menstrual Cycle _____

Pap Smear _____

III What are your lifestyle habits?

Tobacco(packs/day) _____ Alcohol(drinks/day) _____ Sleep(hours/day) _____

Waking up(#/night) _____ Exercise/Hobbies _____

IV Have you had any previous surgeries or hospitalizations? List condition and date. _____

V What diseases such as cancer, high blood pressure, stroke, heart attack, diabetes, etc., do family members have?

Mother-

Grandmother-

Brothers-

Father-

Grandfather-

Sisters-

Other-

SIGNATURE _____ DATE _____