Medical History Form

General:

1. **Chief Complaint:** What are the main health concerns you wish to address?

   _____

   _____

2. **Current and Past Treatment:** Have you received treatment for these problems?
   □ Yes □ No, if yes, which:
   □ Conventional □ Oriental □ Other: _____
   Please list the names of the physicians you have formerly consulted with for this problem:

   _____

   _____

3. **Hospitalizations and Surgeries:** Have you undergone any hospitalizations or surgeries in the past? □ Yes □ No, if yes, please explain:

   _____

   _____

4. **Medications and Supplements:** What medications and supplements are you currently taking?

   a. Prescription: _____

   b. Non-prescription: _____

   c. Supplements: _____

   d: Herbs: _____

5. **Allergies:** Are you allergic to any medications, foods, or environmental products?
   □ Yes □ No, if yes, please explain:

   _____

   _____

6. **Mental Disorders:** Have you ever been diagnosed with a mental disorder?
   □ Yes □ No, if yes, please explain:

   _____

   _____

7. **Communicable Diseases:** Do you have an active contagious diseases?

☐ Yes ☐ No, if yes, please check:

☐ Tuberculosis	☐ Pertussis	☐ Measles
☐ SARS	☐ Diphtheria	☐ West Nile Virus
☐ Meningitis	☐ Encephalitis	☐ Influenza
☐ Hepatitis A, B, C	☐ HIV/AIDS	☐ Tropical Diseases

☐ Other: _____

8. **Family History:** Please check if applicable

Diseases	Father	Mother	Brother	Sister	
Cancer	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	
Heart Diseases	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	
Mental Illness	☐	☐	☐	☐	
Other	☐	☐	☐	☐	Please explain: _____

System By System: Please check the boxes if applicable

1. Cardiovascular

	Current	Past		Current	Past
Heart Diseases	☐	☐	Heart Murmurs	☐	☐
Chest Pain	☐	☐	Palpitations	☐	☐
Arrhythmia	☐	☐	Fainting	☐	☐
Rheumatic Fever	☐	☐	High Blood Pressure	☐	☐
Stroke	☐	☐	Swelling of Ankles	☐	☐
Varicose Veins	☐	☐	Deep Vein Thrombosis	☐	☐
Easy Bleeding	☐	☐	Easy Bruising	☐	☐
Anemia	☐	☐	Raynaud's Syndrome	☐	☐

Other _____

2. Pulmonary

	Current	Past		Current	Past
Asthma	☐	☐	Pleurisy	☐	☐
Emphysema	☐	☐	Cough	☐	☐
Difficult Breathing	☐	☐	Shortness of Breath	☐	☐
Chronic Bronchitis	☐	☐	Frequent Catching Colds	☐	☐
Sleep Apnea	☐	☐	Cardiac Asthma	☐	☐

Other _____

3. Genitourinary

	Current	Past		Current	Past
Kidney Diseases	☐	☐	Difficult Urination	☐	☐
Frequent Urination	☐	☐	Painful Urination	☐	☐
Incontinence	☐	☐	Urination at Night	☐	☐
Kidney Stones	☐	☐	Urinary Tract Infection	☐	☐

Blood in Urine	☐	☐	Venereal Diseases	☐	☐

Other _____

4. Neurological

	Current	Past		Current	Past
Dizziness	☐	☐	Loss of Balance	☐	☐
Muscle weakness	☐	☐	Paralysis	☐	☐
Numbness	☐	☐	Tingling	☐	☐
Seizures	☐	☐	Epilepsy	☐	☐
Memory Loss	☐	☐	Insomnia	☐	☐
Somnolence	☐	☐			

Other _____

5. Gastrointestinal

	Current	Past		Current	Past
Epigastric Pain	☐	☐	Heartburn	☐	☐
Nausea/Vomitting	☐	☐	Ulcers	☐	☐
Belching	☐	☐	Bloating	☐	☐
Gall Bladder Diseases	☐	☐	Liver Diseases	☐	☐
Abdominal Pain	☐	☐	Hemorrhoid	☐	☐
Blood in Stool	☐	☐	Undigested Food in Stool	☐	☐
Loose Stool	☐	☐	Constipation	☐	☐
Frequent Passing Gas	☐	☐			

Other _____

6. Endocrine

	Current	Past		Current	Past
Hypothyroid	☐	☐	Excessive Thirst	☐	☐
Hyperthyroid	☐	☐	Excessive Hunger	☐	☐
Hypoglycemia	☐	☐	Night sweating	☐	☐
Diabetes	☐	☐	Feeling of Hot or Cold	☐	☐

Other _____

7. Head

	Current	Past		Current	Past
Headaches	☐	☐	Teeth Grinding	☐	☐
Migraine	☐	☐	TMJ/Jaw Problems	☐	☐
Head Injury	☐	☐	Trigeminal Neuralgia	☐	☐
Cluster headache	☐	☐			

Other _____

8. Neck

	Current	Past		Current	Past
Lumps	☐	☐	Neck Pain	☐	☐
Goiter	☐	☐	Whiplash	☐	☐
Swollen Glands	☐	☐			

Other _____

9. Eye, Ear, Nose, Mouth, Throat

	Current	Past		Current	Past
Impaired Vision	☐	☐	Sinus Problems	☐	☐
Night Blindness	☐	☐	Hay Fever	☐	☐
Double Vision	☐	☐	Stuffy Nose	☐	☐
Blurred Vision	☐	☐	Loss of Smell	☐	☐
Spots in Eyes	☐	☐	Nose Bleed	☐	☐
Eye Pain	☐	☐	Impaired Hearing	☐	☐
Glaucoma	☐	☐	Ear Ringing	☐	☐
Cataracts	☐	☐	Painful Ear	☐	☐
Excessive Tearing	☐	☐	Dry Throat	☐	☐
Dry Eyes	☐	☐	Sore Throat	☐	☐
Other _____			Chapped Lips	☐	☐

10. Integumentary, Musculoskeletal

	Current	Past		Current	Past
Rashes	☐	☐	Shoulder Pain	☐	☐
Acne, Boils	☐	☐	Arm Pain	☐	☐
Skin Color Changes	☐	☐	Upper Back Pain	☐	☐
Lumps	☐	☐	Middle Back Pain	☐	☐
Eczema	☐	☐	Lower Back Pain	☐	☐
Hives	☐	☐	Leg Pain	☐	☐
Psoriasis	☐	☐	Arthritis	☐	☐
Itching	☐	☐	Joint Pain	☐	☐
Hair Loss	☐	☐	Muscle Spasms	☐	☐
Brittle Nails	☐	☐			
Other _____					

11. Immune

	Current	Past
Chronic Fatigue	☐	☐
Low-grade Fever	☐	☐
Chronic Infections	☐	☐
Slow Wound Healing	☐	☐

Other _____

12. Reproductive System

Male

	Current	Past
Hernia	☐	☐
Sexual difficulties	☐	☐
Premature ejaculation	☐	☐
Penile discharge	☐	☐
Genital warts	☐	☐
Chlamydia	☐	☐
Gonorrhea	☐	☐
Syphilis	☐	☐
Herpes	☐	☐

Female

	Current	Past
Age of first mense?		
Age of menopause?		
Length of cycle?		
Duration of menses?		
Irregular cycles	☐	☐
PMS	☐	☐
Heavy flow	☐	☐
Clotting	☐	☐
Menopausal symptoms	☐	☐

	Current	Past
Prostate problem	☐	☐
Testicular pain	☐	☐
Testicular swelling	☐	☐
Other		

_____

	Current	Past
Vaginal discharge	☐	☐
Date of last PAP exam?		
Endometriosis	☐	☐
Ovarian cysts	☐	☐
Breast lumps	☐	☐
Nipple discharge	☐	☐
Pain with intercourse	☐	☐
Vaginal dryness	☐	☐
Cervical dysplasia	☐	☐
Genital warts	☐	☐
Chlamydia	☐	☐
Gonorrhea	☐	☐
Herpes	☐	☐
Syphilis	☐	☐
Birth control?		
Number of pregnancy?		
Number of live birth?		
Number of miscarriages?		
Number of abortions?		
Difficulty conceiving	☐	☐
Other		

_____

13. Mental/Emotional

	Current	Past
Mood swings	☐	☐
Depression	☐	☐
Nervousness	☐	☐
Bi-polar	☐	☐
Psychosis	☐	☐
Anxiety	☐	☐

	Current	Past
Neurosis	☐	☐
ADHD	☐	☐
Hallucinations	☐	☐
Suicidal thoughts	☐	☐
Mental tension	☐	☐
Other		

_____