MEDICAL HISTORY

***PATIENT NAME:_____________________________ DOB:___________ APPOINTMENT:________**

VITALS: HT:_____ WT: ______ BP: _____/_____ TEMP: ______ PULSE:_____ O2%:_______

*Please list, in order, health and emotional problems which ***presently*** trouble you the most. Start with #1 as the most troublesome.

Symptom	How Long?	Symptom	How Long?
1 -		**6-**	
2 -		**7-**	
3 -		**8-**	
4-		**9-**	
5-		**10-**	

Is there any particular situation or event after which major problems began or became worse?

____

____

____

____

List other health practitioners you are currently seeing (or have seen in the past for current problems). Include: family doctors, specialists, physiotherapists, chiropractors, massage therapists, acupuncturists, herbalists, naturopaths, etc.

Practitioner	Specialty	Practitioner	Specialty

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DR.'S NOTES ONLY: ☐**AI Documentation**

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MEDICAL HISTORY

*List all surgical procedures in the past, including approximate age at the time. (include wisdom teeth and circumcision)

Surgical Procedure	Age or Year	Surgical Procedure	Age or Year
1 -		**5 -**	
2 -		**6 -**	
3 -		**7 -**	
4-		**8-**	

Have you had any of the following:
☐ Blood transfusions:_____ ☐ Colonoscopy (years): _____ ☐ Abnormal Colonoscopy?_____
Dental Work: ☐ Braces ☐ Silver fillings Other:_____

List accidents or injuries to head and/or body (when and what was injured):

_____
_____
_____

List chronic ongoing conditions (ie – Diabetes, High blood pressure, High cholesterol, Cancer, Arthritis, Asthma, Osteoporosis, Thyroid disease, etc.) and past health challenges (ie – Rheumatic fever, Kidney stones, etc.)

_____
_____
_____
_____

ADULT FEMALES ONLY:
Age of first menstrual period:_____ Last Menstrual period (start date): _____ Are periods regular: ☐Yes ☐No
Number of pregnancies: _____ Miscarriages:_____ Abortions:_____ Infertility issues:_____
History of contraceptive use or hormone replacement therapy: ☐Yes ☐No How Long?_____
Date of last Pelvic/PAP exam: _____ Breast exam: _____ History of abnormal PAP smear? ☐Yes ☐No
Last Breast screening & date: Mammogram: _____ Ultrasound: _____ Thermogram: _____
Gynecologic procedures: ☐Yes ☐No Please list: _____

***PERSONAL HISTORY:**
Where Born:_____ Birth WT:_____
Birth Order / # Siblings:_____/_____
Countries Lived in: _____ Education:_____ Degree(s) In:_____
As a Baby: ☐Milk Allergy ☐Colic ☐Feeding Problems: _____
☐Frequent Diarrhea ☐Frequent ear/throat or other infections:_____

Employment (please list work experiences of the past 2 years, current job first):

Employment	Employment
1	**3**
2	**4**

Hobbies (please list recreational activities and special interests):

_____
_____
_____

MEDICAL HISTORY

***HABIT HISTORY**

Alcohol use: ☐Yes ☐ No ☐ Quit ☐ If Yes, Preferred type of Alcohol:_____
When was the last time you had more than - ☐ 5 alcoholic drinks in one day (for men)?_____
☐ 4 alcoholic drinks in one day (for women)?_____

Smoking: ☐Never Smoked ☐ Current Smoker How much: _____ How long: _____
☐Smoked in past How much: _____ How long:_____ When Quit:_____
☐E-cigarette usage How long: _____ Type:_____ When Quit:_____
☐Smokeless tobacco (chewing type, snuff)
☐ 2nd Hand Tobacco Smoke Exposure: _____

Drug Use: ☐Never ☐Current ☐Past Type:_____ How often:_____

***DIET HISTORY:**

Please indicate the daily amount you consume of all the following:
Coffee (caffeinated):_____ Decaffeinated:_____ Tea (green, black):_____ Herbal Tea:_____
Regular soft drinks: _____ Diet soft drinks: _____

Meat(s): _____ Milk/Dairy:_____ Breads:_____ Sugar: _____ Chocolate:_____
Ounces of Water / day:_____ Juice: _____ Other:_____

Are you on a special diet now? ☐Yes ☐No What kind / which?_____
How often do you usually eat meals?_____
Do you snack? ☐Yes ☐ No What foods?_____
Do you have any strong food cravings? ☐Yes ☐No For what:_____
Do you get sick if you don't eat for long periods? ☐Yes ☐No What symptoms? _____
Do you ever develop unpleasant symptoms after eating? ☐Yes ☐No What symptoms? _____
Have you had a sudden unexplained weight gain at any time in the past? ☐Yes ☐No
Have you had sudden unexplained weight loss? ☐Yes ☐No Are You: ☐Underweight ☐Overweight ☐Normal
Do you frequently diet or cut back on food intake to control your weight? ☐Yes ☐No

Exercise: ☐Very little activity ☐Relatively active How often? ☐ Never ☐ Occasional ☐2-3 times/week ☐ Daily
Formal exercise? ☐ Yes ☐No Type:_____ How often:_____
How do you feel during and after exercise?_____

***ALLERGY / ADVERSE REACTION HISTORY:**

Allergy tests in the past? ☐Yes ☐No Type:_____
Allergy treatment: Desensitization injections: ☐Yes ☐ No How long?_____
Adverse reactions to **MEDICATIONS** (list the medications and reaction):

MEDICATION	REACTION	MEDICATION	REACTION

Adverse reaction / allergy to Inhalants (pollens, dust, mold, animals): _____

Food allergies / sensitivities: _____

MEDICAL HISTORY

***MEDICATION / SUPPLEMENT USE:**

Current medication and dosages (including prescription drugs, non-prescription drugs, vitamins, hormones, minerals, glandulars, or nutritional supplements). ***Bring all of you medications / supplements with you to your appointment.***

MEDICATION / SUPPLEMENT	DOSAGE	HOW OFTEN	WHO PRESCRIBED

***FAMILY MEDICAL HISTORY (BLOOD RELATIVES ONLY), LIST SPECIFIC RELATIONSHIP – PARENT, SISTER, COUSIN, ETC.**

Allergies (including asthma, hay fever, eczema):	Arthritis (type):
Diabetes:	Fibromyalgia:
Migraine Headaches:	Drug Dependency:
Heart disease/Strokes:	Alcohol Dependency:
High Blood Pressure:	Depression:
Hereditary Cholesterol:	Mental Illness:
Osteoporosis:	Thyroid Dysfunction:
Alzheimer's / Dementia:	Autoimmune Disease:
Parkinson's:	Obesity:
Cancers:	