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Please take a few moments to answer the following questions. All information is confidential.

Name_____ Date of Birth_____ Age_____

Male Female Height_____ Weight_____ Hand Dominance Right Left

Reason for today's visit:_____

_____

Medical History Please Check Yes or No. If Yes, Please Describe.

Yourself_____ **Family Member(s)**_____

NO	YES_____	Arthritis	NO	YES_____
NO	YES_____	Back Disorder	NO	YES_____
NO	YES_____	Cancer	NO	YES_____
NO	YES_____	Diabetes	NO	YES_____
NO	YES_____	Epilepsy	NO	YES_____
NO	YES_____	Stomach Problems	NO	YES_____
NO	YES_____	Gout	NO	YES_____
NO	YES_____	High Blood Pressure	NO	YES_____
NO	YES_____	Heart Condition	NO	YES_____
NO	YES_____	Bleeding Disorder	NO	YES_____
NO	YES_____	Blood Clots	NO	YES_____
NO	YES	Other	NO	YES

Past surgeries_____ **Descriptions**_____ **Year**_____

_____

_____

_____

Current medications

_____

_____

_____

Allergies to Medications

_____

_____

_____

Social History Please circle and list how much

Tobacco	NO	YES_____	Alcohol	NO	YES_____
Marijuana	NO	YES_____	Cocaine	NO	YES_____
Other	NO	YES_____			

Signature_____ Date_____

Please Circle yes if you have had any of the following symptoms or conditions. Check no if you have not had any of the following symptoms or conditions.

Head and Nerves		
Frequent or severe headache	Yes	No
Dizziness or loss of balance	Yes	No
Fainting	Yes	No
Seizures	Yes	No
Stroke	Yes	No
Weakness of arms and legs	Yes	No
Numbness of arms or legs	Yes	No
Shaking or twitching of limbs	Yes	No

Eyes		
Decreased vision	Yes	No
Double Vision	Yes	No
Dry eyes	Yes	No
Eye pain	Yes	No
Eye redness	Yes	No

Ears, Nose, Throat		
Decreased hearing	Yes	No
Noises in ear(s)	Yes	No
Nose bleeds	Yes	No
Stuffy nose	Yes	No
Frequent sore throat	Yes	No
Hoarseness	Yes	No
Difficulty swallowing	Yes	No

Breathing and Lungs	Yes	No
Frequent cough	Yes	No
Frequent colds	Yes	No
Allergies or hay fever	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Emphysema	Yes	No
Shortness of breath		

Heart/Blood Vessels		
Chest pain	Yes	No
Heart disease	Yes	No
High blood pressure	Yes	No
Stroke	Yes	No
Anemia	Yes	No
Blood clots	Yes	No
Bruise easily	Yes	No
Swelling of the ankles and feet	Yes	No

Stomach and Intestines		
Heart burn	Yes	No
Frequent nausea	Yes	No
Vomiting	Yes	No
Stomach problems	Yes	No
Ulcer	Yes	No
Liver problems	Yes	No
Gallbladder disease	Yes	No
Frequent diarrhea	Yes	No
Frequent constipation	Yes	No
Hemorrhoids	Yes	No
Bloody or tarry stool	Yes	No
Loss of bowel control	Yes	No
Hernia	Yes	No

Muscle and Bones		
Spine abnormality	Yes	No
Joint pain, stiffness, or swelling	Yes	No
Tendonitis or bursitis	Yes	No
Broken bones	Yes	No
Muscle wasting	Yes	No

Urinary		
Kidney stones or problems	Yes	No
Bladder problems	Yes	No
Blood in urine	Yes	No
Painful urination	Yes	No
Frequent urination	Yes	No
Difficulty urinating	Yes	No
Urinary tract infection	Yes	No
Loss of urinary control	Yes	No

Female Organs		
Breast pain	Yes	No
Painful periods	Yes	No
Excessive menstrual bleeding	Yes	No
Tumors of uterus or ovary	Yes	No
Painful intercourse	Yes	No

Male Organs		
Abnormalities of testicles	Yes	No
Abnormalities of penis	Yes	No
Erectile difficulty	Yes	No
Pain during sex	Yes	No

Glands	Yes	No
Diabetes	Yes	No
Thyroid problems	Yes	No

Skin		
Rash	Yes	No
Psoriasis	Yes	No
Eczema	Yes	No
Dermatitis	Yes	No

Emotional		
Physical, Sexual, Emotional Abuse	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Difficulty sleeping	Yes	No
Frequent nightmares	Yes	No
Irritability	Yes	No
Pressure at home	Yes	No
Problems at work	Yes	No

Miscellaneous		
Fatigue	Yes	No
Fever	Yes	No
Weight gain	Yes	No
Weight loss	Yes	No
Loss of appetite	Yes	No

Signature: _____ Date: _____