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MEDICAL HISTORY INFORMATION

Patient Name _____

Current illness or problem for which you are seeking treatment today: _____

_____

_____

If female are you currently pregnant? Yes No

Check the conditions you have now or have had in the past:

- ☐ Asthma
- ☐ Persistent cough
- ☐ Coughing of blood
- ☐ Shortness of breath
- ☐ Other lung disease, type _____
- ☐ High blood pressure
- ☐ High blood cholesterol
- ☐ Heart disease
- ☐ Heart attack
- ☐ Mitral valve prolapse
- ☐ Unexplained chest pain
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Diabetes
- ☐ Persistent nausea
- ☐ Change in bowel habits
- ☐ Increase or decrease in appetite
- ☐ Loss of taste
- ☐ Loss or gain of 10 or more pounds
- ☐ Colitis
- ☐ Diverticulitis
- ☐ Blood in urine or stool
- ☐ Kidney/bladder disease
- ☐ Sexually transmitted disease
- ☐ HIV infection/AIDS
- ☐ Other infection, type _____
- ☐ Persistent fatigue
- ☐ Persistent depressed mood
- ☐ Sleep disturbance
- ☐ Persistent increased energy
- ☐ Change in sex drive
- ☐ Stroke
- ☐ Black outs
- ☐ Loss of consciousness
- ☐ Epilepsy
- ☐ Memory problems
- ☐ Frequent headaches
- ☐ Multiple sclerosis
- ☐ Arthritis
- ☐ Rheumatological problems (lupus, joint disease, etc.)
- ☐ Cancer, type _____
- ☐ Alcohol abuse or dependency
- ☐ Drug abuse or dependency
- ☐ Anxiety disorder, type _____
- ☐ Bipolar disorder/manic depression
- ☐ Schizophrenia or other thought disorder
- ☐ Dementia or Alzheimer's disease
- ☐ Personality disorder or problems
- ☐ Hallucinations
- ☐ Thyroid Disease
- ☐ Chronic Pain
- ☐ Other _____