# MEDICAL HEALTH HISTORY

| Name (Last, First, Middle): | Date: |
|---|---|
| | |

Presenting Complaint / Health Problem

| How long has this condition persisted? How did it start? | How severe is the condition? |
|---|---|
| | ___ **(5) Very Severe**<br>___ **(4) Severe** |
| What kind of treatment have you tried in the past? Did it help? | ___ **(3) Moderately Severe** |
| | ___ **(2) Mildly Severe**<br>___ **(1) Not Severe** |

| List the top three areas related to your health that you would like to improve. | Do you have any serious allergies? (Please list) |
|---|---|
| 1) | |
| 2) | |
| 3) | |

Indicate any significant illnesses that you or a close relative had. X=You P=Parent S=Sibling

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | | HIV | | | Neuralgia | | | Rheumatism |
| | | Alcohol / Drug Addiction | | | Goiter | | | Scarlet Fever |
| | | Eating Disorder | | | Epilepsy / Seizures | | | Hernia |
| | | Emphysema | | | Chronic Fatigue | | | Heart Disease |
| | | Arthritis | | | Obesity / Overweight | | | Emotional Imbalance |
| | | Asthma | | | Multiple Sclerosis | | | Psychosis |
| | | Bladder Disorder | | | Nephritis | | | STD |
| | | Polio / Meningitis | | | Stroke | | | Lyme Disease |
| | | Bursitis | | | Hepatitis A – B - C | | | Autoimmune Diseases |
| | | Colitis / Bowel Disorders | | | Candida | | | Kidney Disorder |
| | | Diabetes | | | Cancer | | | Emotional /Physical Abuse |
| | | Mononucleosis | | | Thyroid Problems | | | Bleeding / Blood Disorder |
| | | Gall Stones | | | Ulcers | | | Other ____________________ |

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# MEDICAL HEALTH HISTORY (PAIN SHEET)

| Name (Last, First, Middle): | Date: |
|---|---|
| | |

Please mark an X for each True statement. Check all that apply.

**Location** (Circle Appropriate)

___ Pain radiates / Follows a path
___ Fixed location / Only one spot

**Better or Worse** (Circle Appropriate)

___ Morning
___ Evening / Wakes me
___ Worse / Better with pressure
___ Worse / Better with movement
___ Worse / Better with Cold
___ Worse / Better with Heat

**Characteristics of Pain**

___ Constant
___ Intermittent / Comes & Goes
___ Sore
___ Stabbing
___ Sharp
___ Throbbing
___ Burning
___ Wandering
___ With Spasms
___ With Swelling
___ With Heaviness

How severe is the condition?

___ **(5) Very Severe**

___ **(4) Severe**

___ **(3) Moderately Severe**

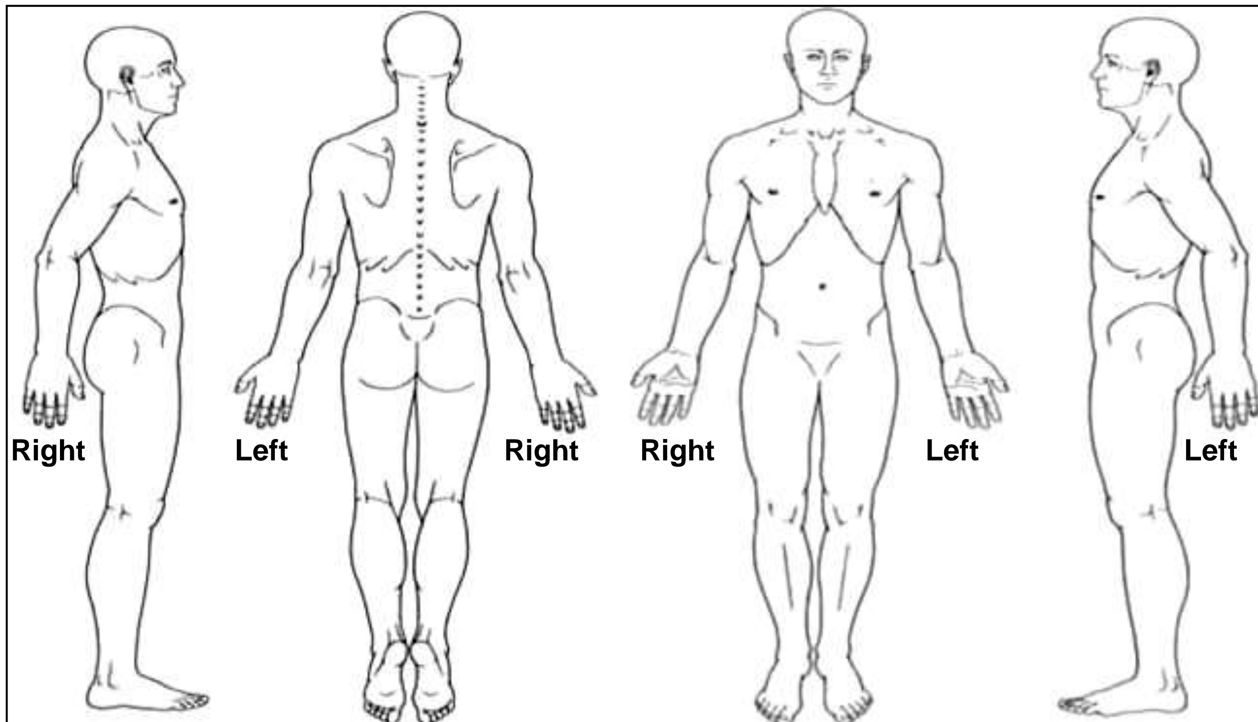
___ **(2) Mildly Severe**

___ **(1) Not Severe**

Please mark on the body diagram with /// or XXX where each pain or symptom is located.

If your pain radiates, draw a line on its path(s).

/// = Pain XXX = Tingling (pins and needles)

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# MEDICAL HEALTH HISTORY SYMPTOMS

| Name (Last, First, Middle): | Date: |
|---|---|
| | |

Please mark an X next to the symptoms you have experienced within the last month or two. Circle appropriate detail.

**HEAT / COLD / SWEATING**

**Tend to feel warm / hot**

__ In Chest / Face / Head
__ In legs / Low back
__ In Hands / Feet
__ In Stomach / Chest
__ Hot Flashes

**Tend to feel cool / cold**

__In Legs /Low back
__In Hands / Feet
__In Stomach / Chest
__Shiver frequently

**Sweating**

__Sweat with little effort
__Sweat at night
__Sweat in Hands / Feet

**HEAD / HAIR**

__ Headaches / Migraines
__ Dizziness / Vertigo
__ Fainting / Feeling faint
__ Foggy feeling in head
__ Twitches face /eye
__ Itchy scalp/dandruff
__ Dry / Brittle hair
__ Hair loss

**BODY**

__ Gaining weight
__ Losing weight
__ Skin: Dry / Itchy / Rash
__ Bruise easily

**RESPIRATORY**

__ Asthma / wheezing
__ Shortness of breath
__ Allergies / Hay Fever
__ Persistent cough
__ Phlegm production
__ Frequent sighing

**MUSCLE / JOINT / BONES**

__ Tremors / Cramps
__ Swollen joints

Pain, weak, numbness in:

__Arms or Hips
__Back
__Legs
__Feet
__Neck
__Hands
__Shoulders

**HUNGER & THIRST**

__ Lack of appetite
__ Aversion to eating
__ Excessive hunger
__ Craving / Picking
__ Dry mouth
__ Frequent thirst
__ Lack of Thirst

Water intake: ________

**DIGESTIVE**

__ Frequent Belching
__ Heartburn / Acid Reflux
__ Frequent Hiccups
__ Bloating / Full feeling
__ Bad breath
__ Difficulty swallowing
__ Indigestion / Nausea / Vomiting
__ Pain over stomach

**GASTROINTESTINAL**

__ Constipation
__ Difficult / Painful BM
__ Diarrhea / Loose Stool
__ Mucous / Blood in stool
__ Hemorrhoids /itching
__ Frequent gas

**URINE**

__ Less than 3 / day
__ More than 5 / day
__ Dark / Yellow / Brown
__ Scanty / Small Amt.
__ Delayed / Start & Stop
__ Long / A lot at a time
__ Pain / Burning
__ Urgency / Incontinence
__ Wake to urinate
__ Blood in urine
__ Cloudy / Turbid
__ Strong odor

**CARDIOVASCULAR**

__ Chest pain
__ Tightness in chest
__ Pain in ribcage / Side
__ High/low blood pressure
__ Pain over heart
__ Poor circulation
__ Hardening of arteries
__ Previous heart attack
__ Rapid/irregular heart beat

**EYES / EARS / NOSE**

__ See floating spots
__ Dry / Watery eyes
__ Redness in eyes
__ Pressure of eyes
__ Ringing sound
__ Difficulty hearing
__ Earaches
__ Congested sinuses
__ Runny nose
__ Dry nostrils
__ Nose bleeds
__ Frequent sneezing

**ENERGY**

__ Fatigued / Low energy
__ Mental fatigue
__ Tired after eating
__ Low sex drive

**MENTAL / EMOTIONAL**

__ Stress at home / Work
__ Impatient / Irritable
__ Worry / Over-thinking
__ Fear / Anxiety
__ Sadness / Depression
__ Lack of drive
__ Forgetfulness / Foggy
__ Feelings of discontent

**SLEEP**

__ Wake rested
__ Difficulty falling asleep
__ Difficulty staying asleep
__ Awaken too early
__ Daytime sleepiness
__ Restless /Dreaming
__ Wake with fright

**MEN ONLY**

__ Genital pain / discharge
__ Prostate issues
__ Impotence

**WOMEN ONLY**

__ Has given birth
__ Cycle: short/long
__ Flow: light/ heavy/ clots
__ Past / In menopause
__ Breast tenderness
__ Anger/frustration
__ Brest lumps /masses
__ Vaginal discharge / dry

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## MEDICAL HEALTH HISTORY MEDICATIONS & SIGNATURE

| Name (Last, First, Middle): | Date: |
| --- | --- |
| | |

Please list any **Prescription Medications –Over the Counter Medications – Supplements – Herbs** you are taking**.**

| Name of Medication | Reason | Dose Taken | How long? |
| --- | --- | --- | --- |
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## SIGNATURE

The information on this form is correct to the best of my knowledge.

Signature________________________________________________________ Date ____________________

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