NAME:_____ DOB:_____ AGE:_____

HEALTH HISTORY

Occupation: _____

_____ Right-handed _____ Left-handed

Height_____ Weight_____

_____ I wear glasses or contacts

_____ I wear dentures or have dental implants

_____ I have had or plan to have dental work/cleaning

I currently smoke _____ packs/day x _____ years

I used to smoke ____ packs/day x ____ years & quit _____

_____ I use a patch, gum, e-cigarette, or chewing tobacco

_____ I am exposed to second-hand smoke/e-cigarettes

_____ I drink _____ alcoholic drinks/week

Other recreational drugs/substances: _____

CURRENT PRESCRIPTIONS AND OVER THE COUNTER MEDICATIONS, VITAMINS, HERBS, AND SUPPLEMENTS:

NAME	REASON	DOSE	FREQUENCY

ALLERGIES	REACTION

PAST SURGERIES	DATE	COMPLICATIONS (IF ANY)

NAME:_____ DOB:_____ AGE:_____

PERSONAL HISTORY OF CANCER: YES NO
Type, treatments & dates: _____
_____
_____
_____
_____

FAMILY HISTORY OF CANCER: YES NO
Type & relationship_____
_____
_____
_____

FAMILY MEDICAL HISTORY: YES NO
Explain: _____
_____
_____

FEMALES:
Are you pregnant: YES NO
Number of pregnancies: _____
Number of children: _____
Are you nursing: YES NO
Date of last mammogram: _____
Where: _____
Results: _____
Have you been through menopause: YES NO
When: _____
Have you had a total hysterectomy
(Including BOTH ovaries): YES NO
Have you had a bilateral tubal ligation
(BOTH "tubes tied"): YES NO

PLEASE *CIRCLE* IF YOU HAVE OR YOU PREVIOUSLY HAD:

CARDIAC
- Chest Pain YES NO
- Heart attack YES NO
  - When: _____
- Heart Disease YES NO
- Heart Stents YES NO
  - When: _____
- High Cholesterol YES NO
- High Blood Pressure YES NO
- Low Blood Pressure YES NO
- Irregular Heart Rhythm/Murmur YES NO
  - Specify: _____
- Pacemaker/Defibrillator YES NO
- Poor Circulation YES NO
- Other: _____

MUSCULOSKELETAL
- Back/Neck Injury YES NO
- Osteoarthritis YES NO
- Rheumatoid Arthritis YES NO
- Fibromyalgia YES NO
- Carpal Tunnel Syndrome YES NO
- Other: _____

HEMATOLOGICAL
- Bruising YES NO
- Clotting Disorder YES NO
- DVT/Blood Clot YES NO
  - Explain: _____
- HIV/AIDS YES NO
- Anemia YES NO
- Other: _____

MENTAL HEALTH
- ADHD YES NO
- Anxiety YES NO
- Depression YES NO

Other: _____

GASTROINTESTINAL/URINARY
- Heartburn/Acid Reflux YES NO
- Hepatitis A, B or C YES NO
- Kidney Failure YES NO
- Ulcers YES NO
- Other: _____

RESPIRATORY
- Asthma YES NO
- Emphysema/COPD YES NO
- Shortness of Breath YES NO
- Sleep Apnea YES NO
  - If yes, CPAP use YES NO
- Snoring YES NO
- Other: _____

ENDOCRINE
- Diabetes YES NO
- Hypoglycemia/Low Blood Sugar YES NO
- HYPERthyroidism YES NO
- HYPOthyroidism YES NO
- Other: _____

NEUROLOGICAL
- Dementia/Alzheimer's Disease YES NO
- Memory Loss YES NO
- Seizures YES NO
- Stroke/TIA YES NO
  - When: _____
- Other: _____

DERMATOLOGICAL
- Skin Cancer YES NO
- Acne YES NO
- Rash YES NO
- Lesions/Sores YES NO
- Other: _____

NAME:_____ DOB:_____ AGE:_____

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS THAT YOU MAY HAVE HAD IN THE PAST MONTH AND EXPLAIN BELOW.

GENERAL:
- Weight Change
- Sleep change
- Appetite change
- Fatigue
- Fever or chills

HEENT:
- Headaches
- Head injury
- Vision changes
- Eye pain
- Red eyes
- Flashing lights
- Glaucoma
- Cataracts
- Decreased hearing
- Ringing in ears
- Earache
- Discharge from ear
- Nasal stuffiness or discharge
- Itchy nose
- Hay fever
- Nose bleeds
- Problems with teeth or gums
- Dry mouth
- Sore throat
- Hoarseness
- Swollen glands
- Lumps in neck
- Goiter

NEUROLOGICAL:
- Tremor
- Dizziness
- Lightheadedness
- Fainting
- Paralysis
- Numbness
- Tingling

ENDOCRINE:
- Heat or cold intolerance
- Excessive sweating
- Change in glove or shoe size

RESPIRATORY:
- Cough
- Sputum
- Coughing/spitting up blood
- Wheezing
- Pain with breathing
- Tuberculosis exposure
- Sinus pain

CARDIOVASCULAR:
- Tightness in chest
- Heart palpitations
- Edema

GI:
- Difficulty swallowing
- Nausea/vomiting
- Bloody stool
- Constipation
- Diarrhea
- Abdominal Pain

GU:
- Difficulty urinating
- Urinary infections
- Night urination
- Urinary frequency
- Urgency
- Burning
- Kidney stones
- Incontinence
- Lumps/bumps
- Genital discharge
- STD's

BLOOD:
- Leg cramps
- Varicose veins
- Transfusion
- Bleed easily

MUSCULOSKELETAL:
- Muscle or joint pain
- Muscle cramps
- Stiffness
- Gout
- Swelling
- Neck Pain or stiffness

IMMUNOLOGICAL:
- Delayed healing

PSYCH:
- Nervousness
- Stress
- Disturbing thoughts

SKIN:
- Change in hair or nails
- Non-healing wounds
- Previous wound infection
- Color changes
- Dry skin
- Itchy skin

PLEASE EXPLAIN: