

### Patient's Personal History

NAME:

DATE:

**CONFIDENTIAL RECORD:** Information contained here will not be released except when you have authorized us to do so.

**Present Medications:** Please list all your current prescription and non-prescription medications (including ones you take only occasionally and drugs such as birth control pills, pain pills, and laxatives/antacids).

Do you have any **drug allergies** (rash/hives/asthma) or **sensitivities**?

### Past/Current Medical History

Do you have any **current or ongoing medical problems**? If so, for how long?  
(On this and future questions, circle answers if appropriate.)

diabetes

high blood pressure

thyroid disease

heart disease

arthritis

anemia

elevated cholesterol

gastrointestinal disorder

dementia

lung disease

kidney

other

Have you ever been hospitalized for **serious illnesses**?

heart attack

stroke

seizures

meningitis/encephalitis

mental illness

other

Have you had any **surgeries**? If yes, what operation and in what years:

Serious **injuries** or **accidents** (especially to head, spine, or limbs):

## Family History

Age (s) (If deceased, age and cause of death)

Father  
Mother  
Sisters (#)  
Brothers (#)  
Children (#)

Do you have a family history of:

stroke	tremor	depression
heart attack	Parkinson's	suicide
epilepsy	diabetes	alcoholism
multiple sclerosis	migraine	movement disorder
dementia	neuropathy	other

## Social History

Marital Status:      S      M      D      W      Occupation:

Highest level of education:

**Do/did** you smoke/chew **tobacco**?

If yes, \_\_\_\_\_ packs/day for \_\_\_\_\_ years.

Do you drink **alcohol**?

If yes, how much?

**Do/did** you ever use recreational drugs?

If yes, what substance?

Do you use **caffeine** (coffee/tea/cola)?

If yes, how many cups or glasses a day?

Have you been exposed to any **serious poisons or toxins**?

Are you under much **stress**?

from your job?

from your personal life:

Do you get formal **exercise**?

## Review of Systems

Is there a problem with your:

general health:

- |                          |                       |                       |
|--------------------------|-----------------------|-----------------------|
| - weight                 | - energy level        | - bruising            |
| - anxiety/depression     | - sleeping pattern    | - swollen nodes/bumps |
| - tolerance of heat/cold | - skin, nails or hair |                       |

head:

- |                          |                        |
|--------------------------|------------------------|
| - eyes/vision            | - teeth/gums           |
| - nose/sinuses/allergies | - TMJ (jaw joint pain) |
| - ears/balance/hearing   | - headaches            |

neck?

shoulders?

low back?

arms/legs?

chest?

- heart (chest pains/palpitations...)
- lungs (asthma, emphysema, shortness of breath)

stomach:

- |                              |                   |
|------------------------------|-------------------|
| - heartburn, ulcers          | - sexual function |
| - liver/pancreas/gallbladder | - bladder         |
| - bowels                     |                   |

Women: date of last menstrual period: \_\_\_\_\_ Periods regular?