**Patient Name:** _____ **Date:** _____

Please mark in the box next to all symptoms you currently have or have had in the past.

**GENERAL**

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Poor appetite |
| ☐ | ☐ | Excessive appetite |
| ☐ | ☐ | Insomnia |
| ☐ | ☐ | Fatigue |
| ☐ | ☐ | Fevers |
| ☐ | ☐ | Night sweats |
| ☐ | ☐ | Sweat easily |
| ☐ | ☐ | Chills |
| ☐ | ☐ | Localized weakness |
| ☐ | ☐ | Poor coordination |
| ☐ | ☐ | Change in appetite |
| ☐ | ☐ | Strong thirst |
| ☐ | ☐ | Other _____ |

**SKIN AND HAIR**

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Rashes |
| ☐ | ☐ | Hives |
| ☐ | ☐ | Itching |
| ☐ | ☐ | Eczema |
| ☐ | ☐ | Pimples |
| ☐ | ☐ | Dryness |
| ☐ | ☐ | Tumors/lumps |
| ☐ | ☐ | Other _____ |

**HEAD AND NECK**

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Fainting |
| ☐ | ☐ | Neck stiffness |
| ☐ | ☐ | Enlarged lymph glands |
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Concussions |
| ☐ | ☐ | Dizziness |
| ☐ | ☐ | Other _____ |

**EARS**

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Infection |
| ☐ | ☐ | Ringing |
| ☐ | ☐ | Decreased hearing |
| ☐ | ☐ | Discharge |
| ☐ | ☐ | Other_____ |

**EYES**

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Blurred vision |
| ☐ | ☐ | Visual changes |
| ☐ | ☐ | Poor night vision |
| ☐ | ☐ | Spots |
| ☐ | ☐ | Cataracts |
| ☐ | ☐ | Glasses/Contacts |
| ☐ | ☐ | Eye inflammation |
| ☐ | ☐ | Other _____ |

**CARDIOVASCULAR**

| Past | Current | |
|---|---|---|
| ☐ | ☐ | High blood pressure |
| ☐ | ☐ | Low blood pressure |
| ☐ | ☐ | Blood clots |
| ☐ | ☐ | Palpitations |
| ☐ | ☐ | Fainting |
| ☐ | ☐ | Phlebitis |
| ☐ | ☐ | Chest pain/Angina |
| ☐ | ☐ | Irregular heart beat |
| ☐ | ☐ | Cold hands/feet |
| ☐ | ☐ | Swelling of hands/feet |
| ☐ | ☐ | Pacemaker |
| ☐ | ☐ | Other _____ |

**RESPIRATORY**

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Bronchitis |
| ☐ | ☐ | Frequent colds |
| ☐ | ☐ | Pneumonia |
| ☐ | ☐ | Cough |
| ☐ | ☐ | Coughing blood |
| ☐ | ☐ | Production of phlegm |
| ☐ | ☐ | Emphysema |
| ☐ | ☐ | Shortness of breath |
| ☐ | ☐ | Chronic obstructive pulmonary disease |
| ☐ | ☐ | Other _____ |

**GASTRO-INTESTINAL**

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Nausea |
| ☐ | ☐ | Vomiting |
| ☐ | ☐ | Diarrhea |
| ☐ | ☐ | Belching |
| ☐ | ☐ | Blood in stools/black stools |
| ☐ | ☐ | Bad breath |
| ☐ | ☐ | Rectal pain |
| ☐ | ☐ | Hemorrhoids |
| ☐ | ☐ | Constipation |
| ☐ | ☐ | Pain or cramps |
| ☐ | ☐ | Indigestion |
| ☐ | ☐ | Gall bladder disorder |
| ☐ | ☐ | Gas |
| ☐ | ☐ | IBS |
| ☐ | ☐ | Heartburn |
| ☐ | ☐ | Other _____ |

**GENITO-URINARY**

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Kidney stones |
| ☐ | ☐ | Pain on urination |
| ☐ | ☐ | Frequent urination |
| ☐ | ☐ | Blood in urine |
| ☐ | ☐ | Urgency to urinate |
| ☐ | ☐ | Unable to hold urine |
| ☐ | ☐ | Other _____ |

**FEMALE**

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Frequent urinary tract infections |
| ☐ | ☐ | Frequent vaginal infections |
| ☐ | ☐ | Pain/itching of genitalia |
| ☐ | ☐ | Genital lesions/discharge |
| ☐ | ☐ | Pelvic inflammatory disease |
| ☐ | ☐ | Abnormal pap smear |
| ☐ | ☐ | Irregular periods |
| ☐ | ☐ | Painful menstrual periods |
| ☐ | ☐ | Premenstrual syndrome |
| ☐ | ☐ | Abnormal bleeding |
| ☐ | ☐ | Menopausal syndrome |
| ☐ | ☐ | Breast lumps |
| ☐ | ☐ | Other _____ |

**NEUROLOGICAL**

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Tremors |
| ☐ | ☐ | Numbness or tingling of limbs |
| ☐ | ☐ | Concussion |
| ☐ | ☐ | Pain |
| ☐ | ☐ | Paralysis |
| ☐ | ☐ | Other _____ |

**PSYCHOLOGICAL**

| Past | Current | |
|---|---|---|
| ☐ | ☐ | Depression |
| ☐ | ☐ | Anxiety/Stress |
| ☐ | ☐ | Irritability |
| ☐ | ☐ | Emotional/Psychological issues |
| ☐ | ☐ | Mania/bipolar |
| ☐ | ☐ | PTSD |
| ☐ | ☐ | Other _____ |

**MALE**

| Past | Present | |
|---|---|---|
| ☐ | ☐ | Pain/itching of genitalia |
| ☐ | ☐ | Genital lesions/discharge |
| ☐ | ☐ | Impotence |
| ☐ | ☐ | Weak urinary stream |
| ☐ | ☐ | Lumps in testicles |
| ☐ | ☐ | Prostatitis |
| ☐ | ☐ | Other _____ |

**NOSE, THROAT, AND MOUTH**

| Past | Present | |
|---|---|---|
| ☐ | ☐ | Nose bleeds |
| ☐ | ☐ | Sinus infection |
| ☐ | ☐ | Hay fever or allergies |
| ☐ | ☐ | Recurring sore throats |
| ☐ | ☐ | Grinding teeth |
| ☐ | ☐ | Difficulty swallowing |

**Patient History (continued)**

**Patient Name:** _____ **Date:** _____

**Family History**: Complete for each family member, placing an X in the appropriate box.

| | Self | Mother | Father | Brother | Sister | Grandparents | Child |
|---|---|---|---|---|---|---|---|
| Allergies | | | | | | | |
| Blood Disorder/ Anemia | | | | | | | |
| Diabetes | | | | | | | |
| Cancer or Tumors | | | | | | | |
| Seizures | | | | | | | |
| Kidney/ Bladder Disorder | | | | | | | |
| Stomach/Intestinal Disorder | | | | | | | |
| Drug/ Alcohol Abuse | | | | | | | |
| Tuberculosis | | | | | | | |
| Heart Disease | | | | | | | |
| Stroke | | | | | | | |
| Depression/ Mental Illness | | | | | | | |
| Anxiety | | | | | | | |
| Arthritis | | | | | | | |
| Asthma | | | | | | | |
| Back Problems | | | | | | | |
| Bursitis | | | | | | | |
| Constipation | | | | | | | |
| Headaches | | | | | | | |
| Hepatitis | | | | | | | |
| High Blood Pressure | | | | | | | |
| HIV/AIDS | | | | | | | |
| Immune Disorder | | | | | | | |
| Insomnia | | | | | | | |
| Kidney Problems | | | | | | | |
| Liver Problems | | | | | | | |
| Migraines | | | | | | | |
| Neck Pain | | | | | | | |
| Thyroid Disorder | | | | | | | |
| Weight Problems | | | | | | | |
| Emotional Problems | | | | | | | |
| Other | | | | | | | |
| Age at Death | | | | | | | |

**Major Hospitalizations**: List the most recent hospitalizations for any serious medical illness or operation.

| Year | Operation or Illness | Hospital Name | City, State |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Medications / Supplements**: List all medications, supplements, vitamins and herbs you use, including those used only on occasion.

| Name | Purpose | How long | Dose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| **Drug Allergies:** |
|---|
| |

**Habits**: Check any of the habits listed below that apply to you now or in the past.

| | | | | | |
|---|---|---|---|---|---|
| Coffee | Yes□ | No□ | Cups per day/ week | Age started | Age quit |
| Tobacco | Yes□ | No□ | Cigarettes per day | Age started | Age quit |
| Marijuana | Yes□ | No□ | Use per day/week | Age started | Age quit |
| Alcohol | Yes□ | No□ | Use per day/week | Age started | Age quit |
| Crack/Cocaine | Yes□ | No□ | Use per day/week | Age started | Age quit |
| Heroin | Yes□ | No□ | Use per day/week | Age started | Age quit |
| Other | Yes□ | No□ | Use per day/week | Age started | Age quit |