Personal Medical History (Current and Past) & Review of Systems

Present Complaints (Please circle the appropriate ones)

Headache	Feet/Hands Cold	Unbalanced
Mental dullness	Depression	Fainting
Loss of memory	Rib pain	Blurred vision
Dizzy	Nervousness	Irritability
Ears ringing/buzzing	Eye strain/pain	Double vision
Upper back pain	Shortness of breath	Loss of smell
Lower back pain	Fear	Chest pain
Midback pain	Confusion	Neck pain
Pins and needles in hands right/left	Pins and needles in arms right/left	Pins and needles in legs right/left

Other not listed_____

Medical Implants: _____ **Medical alerts: _____**

Surgical Implants: _____ **Pregnancy: yes ____ no ____**

Personal Physician_____

PAIN SCALE: Rate the severity of your pain by circling a number on the following scale.

No Pain	0	1	2	3	4	5	6	7	8	9	10	**Excruciating Pain**

Medications: *(please list all medications and supplements that you currently take)*

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Allergies: *(please list all medications that cause allergic reaction)*

_____ _____ _____
_____ _____ _____
_____ _____ _____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____ Date _____

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

□ **NO MEDICAL PROBLEMS** - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

□ asthma	□ pulmonary embolism	□ respiratory arrest
□ COPD	□ pneumonia	□ sleep apnea
□ emphysema	□ tuberculosis	□ other: _____

Cardiac / Heart and peripheral vascular disease

□ chest pain / angina
□ heart attack, myocardial infarction
□ congestive heart failure
□ other: _____
□ high blood pressure
□ heart murmur, valve disorder
□ mitral valve prolapse
□ bleeding problems
□ irregular heartbeat, arrhythmia
□ peripheral vascular disease
□ deep vein thrombosis

Neurologic Disorders

□ stroke or TIA
□ peripheral neuropathy
□ other: _____
□ parkinson's
□ MS
□ cerebral palsy
□ polio

Bone & Joint Disorders

□ osteoarthritis
□ rheumatoid arthritis
□ other: _____
□ gout
□ lupus
□ osteomyelitis
□ ankylosing spondylitis

Gastrointestinal Disorders

□ peptic ulcer or stomach ulcer
□ acid reflux, GERD
□ GI bleed
□ other: _____
□ diverticulitis
□ irritable bowel
□ inflammatory bowel disease
□ hepatitis - Type _____
□ liver disease

Genitourinary Disorders

□ urinary tract infection
□ bladder problems
□ kidney problems
□ kidney stones
□ dialysis, kidney failure
□ other: _____

Metabolic & Other Disorders

□ Diabetes x _____ years
□ thyroid problems
□ sickle cell disease
□ high cholesterol or lipids
□ skin disorder _____
□ psoriasis
□ any skin ulcer
□ tooth abscess, gingivitis
□ depression
□ anxiety
□ alcohol or drug dependency
□ other: _____

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____
_____
_____

Family History:

Please indicate with an "X" any significant family medical history or problems.

□ asthma
□ COPD or Emphysema
□ tuberculosis
□ other lung :_____
□ sleep apnea
□ heart attack, myocardial infarction
□ irregular heartbeat, arrhythmia
□ other heart :_____
□ congestive heart failure
□ bleeding problems
□ Peripheral neuropathy
□ osteoarthritis
□ rheumatoid arthritis
□ acid reflux, GERD
□ hepatitis - Type _____
□ liver disease
□ kidney problems
□ diabetes
□ thyroid problems
□ Malignant hyperthermia
□ MS or Parkinson's
□ Lupus
□ Other bone & joint: _____
□ inflammatory bowel disease
□ other GI :_____
□ dialysis, kidney failure
□ psoriasis
□ sickle cell disease
□ other neuro :_____
□ gout
□ high cholesterol or lipids
□ any skin ulcer

Cancer : any type -- please specify _____

Other medical problems NOT included above (explain) _____

All Information I have provided above and to this office is true and accurate to my knowledge. I understand that providing incorrect information can be dangerous to my health.

Signature_____ Date_____