CONFIDENTIAL HEALTH HISTORY

SELF

Please indicate with a check if YOU have had any of the following:

GENERAL
1) ___ night sweats
2) ___ fatigue
3) ___ excessive weight loss
4) ___ excessive weight gain
5) ___ allergies
6) ___ bleeding problems
7) ___ anemia
8) ___ diabetes
9) ___ cancer
10) ___ thyroid disease
11) ___ alcoholism
12) ___ drug abuse

EENT
13) ___ poor vision
14) ___ pain in eye
15) ___ difficulty hearing
16) ___ sinus problems
17) ___ trouble breathing
18) ___ halitosis
19) ___ hoarseness

GI
20) ___ poor appetite
21) ___ poor digestion
22) ___ difficulty swallowing
23) ___ belching or gas
24) ___ frequent nausea
25) ___ vomiting
26) ___ stomach pain
27) ___ ulcer
28) ___ black or bloody stool
29) ___ liver problems
30) ___ gall bladder problems
31) ___ diarrhea
32) ___ constipation
33) ___ appendicitis

RESPIRATORY
34) ___ difficulty breathing
35) ___ chronic cough
36) ___ spitting phlegm
37) ___ wheezing/asthma
38) ___ pneumonia
39) ___ tuberculosis

CARDIOVASCULAR
40) ___ irregular heartbeat
41) ___ high blood pressure
42) ___ pain over heart
43) ___ previous heart trouble
44) ___ ankle swelling
45) ___ rheumatic fever
46) ___ stroke

GU
47) ___ frequent urination
48) ___ painful urination
49) ___ blood in urine
50) ___ kidney disease
51) ___ urinary infection
52) ___ inability to control urination
53) ___ difficulty starting urine flow
54) ___ get up at night to urinate
55) ___ breast lump or pain
56) ___ sexually transmitted disease
57) ___ sexual difficulties

MUSCULOSKELETAL
58) ___ neck stiffness/pain
59) ___ pain between shoulders
60) ___ low back pain
61) ___ swollen joints
62) ___ painful joints
63) ___ muscle aches/soreness
64) ___ scoliosis
65) ___ arthritis

NEUROLOGICAL
58) ___ weakness
59) ___ tremors
60) ___ headaches
61) ___ fainting
62) ___ dizziness
63) ___ convulsions
64) ___ epilepsy
65) ___ numbness/tingling
66) ___ arm/leg pain

SKIN
67) ___ itching
68) ___ bruising easily
69) ___ change in mole
70) ___ skin cancer

MALE ONLY
71) ___ testicular swelling
72) ___ prostate problems

FEMALE ONLY
73) ___ painful periods
74) ___ excessive flow
75) ___ irregular cycles
76) ___ vaginal burning
77) ___ hot flashes
78) ___ yeast infections

FAMILY

Please indicate with a check if a sibling, parent, or grandparent has had any of the following. Do not include yourself.

79) ___ diabetes
80) ___ thyroid disease
81) ___ tuberculosis
82) ___ kidney disease
83) ___ high blood pressure
84) ___ heart disease
85) ___ cancer
86) ___ muscle, bone or nerve disease

List all prior major injuries and operations

_____
_____
_____
_____
_____
_____

List all medications/supplements/vitamins

Name	Dose	Date Started

Patient Name: _____ Signature: _____

Date: _____

By signing this form, I hereby certify that the information contained within this form is accurate and true to the best of my knowledge.