

Name _____	Age _____	Single Married	Divorced Widow(er)	Date _____
Occupation _____	All Previous Occupations _____			
Birth Place _____	Birthdate _____	List all States in which you have lived _____		
Education: _____ years High School _____ years College _____ years Post Grad		Who referred you to our office? _____		
Date of last complete blood work _____	Has any blood relative ever had:	Please encircle		Who
Date of last physical examination _____	Cancer	No	Yes	
Please list all current Symptoms	Diabetes	No	Yes	
1. _____	Heart Trouble	No	Yes	
2. _____	High Blood Pressure	No	Yes	
3. _____	High Cholesterol	No	Yes	
4. _____	Stroke	No	Yes	
Routine Check-up – No Symptoms <input type="checkbox"/>	Thyroid Disease	No	Yes	
If Living		If Deceased		
Age	Health	Age at death	Cause	
Father _____	Auto Immune	No	Yes	
Mother _____	Mental Illness	No	Yes	
Brother or Sister 1. _____	Describe			
2. _____	Suicide	No	Yes	
3. _____	Current: Vitamins, Minerals, Herbs	No	Yes	
4. _____	Prescription Medication:	No	Yes	
Husband or Wife _____				
Son or Daughter 1. _____				
2. _____				
3. _____				
4. _____				

PERSONAL HISTORY

ILLNESSES: Have you ever had

PLEASE ENCIRCLE ALL ANSWERS

No Yes

Measles _____ No Yes
 German Measles _____ No Yes
 Mumps _____ No Yes
 Chicken Pox _____ No Yes
 Whooping Cough _____ No Yes
 Scarlet Fever or Scarletina _____ No Yes
 Diphtheria _____ No Yes
 Smallpox _____ No Yes
 Pneumonia _____ No Yes
 Influenza _____ No Yes
 Pleurisy _____ No Yes
 Rheumatic Fever or Heart Disease _____ No Yes
 Arthritis or Rheumatism _____ No Yes
 Any bone or joint disease _____ No Yes
 Neuritis or Neuralgia _____ No Yes
 Bursitis, Sciatica or Lumbago _____ No Yes
 Polio or Meningitis _____ No Yes
 Nephritis _____ No Yes
 Gonorrhea or Syphilis _____ No Yes
 Gallbladder disease _____ No Yes
 Anemia _____ No Yes
 Jaundice _____ No Yes
 Bladder disease _____ No Yes
 Epilepsy _____ No Yes
 Migraine headaches _____ No Yes
 Tuberculosis _____ No Yes
 Diabetes _____ No Yes

Cancer _____ No Yes
 High or low blood pressure _____ No Yes
 Colitis or other bowel disease _____ No Yes
 Hemorrhoids or any rectal disease _____ No Yes
 Nervous Breakdown _____ No Yes
 Food, chemical or drug poisoning _____ No Yes
 Hay Fever or Asthma _____ No Yes
 Hives or Eczema _____ No Yes
 Frequent infections or boils _____ No Yes
 AIDS _____ No Yes
 Any other disease _____ No Yes
 ALLERGIES: Are you allergic to
 Penicillin or Sulfa _____ No Yes
 Aspirin, Codeine or Morphine _____ No Yes
 Mycins or other Antibiotics _____ No Yes
 Iodine _____ No Yes
 Any other drug _____ No Yes
 Adhesive Tape _____ No Yes
 Nail polish or other cosmetics _____ No Yes
 INJURIES: Have you had any
 Broken or cracked bones _____ No Yes
 Sprains _____ No Yes
 Concussion, or head injury _____ No Yes
 Ever been knocked unconscious _____ No Yes
 WEIGHT: Now _____ No Yes
 One Year Ago _____
 Maximum _____ When _____

TRANSFUSIONS: Have you ever had
 Blood or Plasma Transfusion _____ No Yes
 SURGERY: Have you had
 Tonsillectomy _____ No Yes
 Appendectomy _____ No Yes
 Any other operation _____ No Yes
 Type _____ Year _____
 Type _____ Year _____
 Type _____ Year _____
 Do you smoke _____ No Yes
 How many per day _____
 _____ Alcohol drinks per day/week/month
 Have you ever been advised to have
 any surgical operation which has
 not been done _____ No Yes
 Have you been hospitalized for
 any illness _____ No Yes
 Give details: _____

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Frequent or severe headaches _____ No Yes
 Fainting spells _____ No Yes
 Dizziness on change of position _____ No Yes
 Unconscious Spells _____ No Yes
 Blurred Vision _____ No Yes
 Double Vision _____ No Yes
 Spots before eyes _____ No Yes
 Infected eyes _____ No Yes
 Pain behind eyes _____ No Yes
 Any change in vision _____ No Yes
 Do you wear glasses _____ No Yes
 When were they last checked _____
 Earaches _____ No Yes
 Discharge from Ears _____ No Yes
 Ringing in ears _____ No Yes
 Decrease in hearing _____ No Yes
 Recurrent nose bleeds _____ No Yes
 Recurrent head colds _____ No Yes
 Sinus Trouble _____ No Yes
 Hay fever _____ No Yes
 Strange persistent odors _____ No Yes
 Strange taste or loss in taste _____ No Yes
 Persistent hoarseness _____ No Yes
 Difficulty swallowing _____ No Yes
 Enlarged glands _____ No Yes
 Recurrent sore throats _____ No Yes
 Recurrent sores in mouth _____ No Yes
 Soreness or bleeding of gums on brushing _____ No Yes
 Chest pain _____ No Yes
 Angina pectoris _____ No Yes
 Coughed up blood _____ No Yes
 Pain in arm(s) _____ No Yes
 Night sweats _____ No Yes
 Chronic or frequent cough _____ No Yes
 Chronic or frequent cough on lying down _____ No Yes
 Wake up at night short of breath _____ No Yes
 How many bed pillows do you use _____
 Shortness of breath on:
 Walking several blocks _____ No Yes
 One flight of stairs _____ No Yes
 On lying down _____ No Yes
 Purple lips or fingers _____ No Yes
 Palpitations or fluttering heart _____ No Yes
 High blood pressure _____ No Yes
 Swelling of hands, feet or ankles _____ No Yes
 At what time of day _____
 Leg cramps on walking or at night _____ No Yes
 Enlarged veins in legs _____ No Yes
 Recurrent stomach pain _____ No Yes
 Belching or heartburn _____ No Yes
 Relieved by food or medication _____ No Yes
 Appetite – Good Fair Poor
 Nausea or vomiting _____ No Yes
 Vomited blood _____ No Yes
 Avoid some foods _____ No Yes
 What kinds _____
 Avoid spices _____ No Yes
 Abdominal cramping _____ No Yes
 Color of bowel movement _____
 Any blood in BM _____ No Yes
 Rectal pain with bowel movement _____ No Yes

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR:

Change in size, shape or texture of BM _____ No Yes
 Describe _____
 Pain on urinating _____ No Yes
 Difficulty in starting urination _____ No Yes
 Do you get up at night to urinate _____ No Yes
 How many times _____
 Urinate more than before _____ No Yes
 Urinate less than before _____ No Yes
 Any blood in urine _____ No Yes
 How many times per day do you urinate _____
 Full feeling of bladder, but only small amount of urination _____ No Yes

Lose urine on coughing or sneezing _____
 Recurrent back pains _____ No Yes
 Backaches _____ No Yes
 Joint pains _____ No Yes
 Swelling of any joints _____ No Yes
 Redness or heat of any joint _____ No Yes
 Tingling or weakness of hands or feet _____ No Yes
 Muscle Spasms _____ No Yes
 Loss or change in sensation of hands or feet _____ No Yes
 Trembling of any extremity _____ No Yes
 Growth in neck or throat _____ No Yes
 Hot flashes _____ No Yes
 Tiredness without apparent reason _____ No Yes
 Brittleness of nails _____ No Yes
 Dryness of skin _____ No Yes
 Easy bruising _____ No Yes
 Inability to stand heat _____ No Yes
 Inability to stand cold _____ No Yes
 Change in hair texture _____ No Yes
 Change in skin texture _____ No Yes
 Any skin rash _____ No Yes

X-RAYS: Have you ever had x-rays of

Chest _____ No Yes
 Stomach or colon _____ No Yes
 Gall bladder _____ No Yes
 Extremities _____ No Yes
 Back _____ No Yes
 Teeth _____ No Yes
 Other _____ No Yes

EKG: Ever had an electrocardiogram?

_____ No Yes

IMMUNIZATIONS: Have you had

Smallpox vaccination within last 7 years _____ No Yes
 Tetanus shots (not antitoxin which lasts only 2 weeks) _____ No Yes
 Polio shots within last 2 years _____ No Yes

DRUGS: Laxatives; never occ. freq. daily
Vitamins; never occ. freq. daily
Sedatives; never occ. freq. daily
Tranquilizers; never occ. freq. daily
Sleeping pills, etc.; never occ. freq. daily
Aspirin, etc.; never occ. freq. daily
Cortisone, ACTH; never occ. freq. daily
Thyroid; never yes, in past, none now
 daily now on _____ gr. day
Appetite depressants never occ. freq. daily

Have you ever been treated for drug habits _____ No Yes
 Have you ever taken insulin or tablets for diabetes _____ No Yes
 Have you ever taken hormone tablets or injections _____ No Yes

SEX: Entirely satisfactory? _____ No Yes

WOMEN ONLY – MENSTRUAL HISTORY

Age at onset _____
 Regular ? Yes No Varies
 Cycle _____ days (from start to finish)
 Flow: Heavy Medium Light
 Any clots passed _____ No Yes
 Pains or cramps _____ No Yes
 Date of last period _____
 Date of last pelvic exam _____
 Date of last Pap Test _____
 Results: Neg. Pos.
 Any discharge from vagina _____ No Yes
 If so, color _____
 amount _____
 Any itching of vaginal area _____ No Yes
 Do you take birth control pills _____ No Yes
 How long have you taken them _____
Pregnancies:
 How many children born alive _____
 How many premature births _____
 How many miscarriages _____
 Any complications with pregnancy _____ No Yes
 Describe _____
 Other _____