NAME _____ DATE _____

PATIENT MEDICAL HISTORY

This is a confidential record of your medical history and will be kept in this office. Information will be released only with your written permission. Please complete the questionnaire as thoroughly as possible. Place a question mark by anything you do not understand. If you have a complicated history, if may help to add your own time line of health problems, testing and treatments tried from earliest recollection to present and list of current symptoms on separate sheets. Please be as complete as possible.

Primary Health Concerns:

When did your health concerns begin?

MAJOR HOSPITALIZATIONS OR ILLNESSES:

Operations	Year	Illnesses Requiring Hospitalization	Year
1.		1.	
2.		2.	
3.		3.	
4.		4.	
5.		5.	

Description and date of any serious injuries or accidents you have had:

List the names of all medications and doses you are currently taking: (See page 2)

List all vitamins, herbs or other supplements you are currently taking: (See page 2)

Medications, supplements, foods or other things you are allergic to:

Please list any foods or tastes that you have particular craving or aversion to:

MEDICATIONS

NAME	DOSE	W/ FOOD	W/O FOOD	AM	MID	PM	BED

SUPPLEMENTS

NAME	DOSE	COMPANY	W/ FOOD	W/O FOOD	AM	MID	PM	BED

REVIEW OF SYMPTOMS AND ILLNESSES

Please Mark _C_ for current / recent or _P_ if the problem was in the past. Circle the correct option if more than one.

HEENT

_____Bleeding gums
_____Eye infections
_____Far / Near sighted
_____Grinding teeth / Jaw pain
_____Mercury fillings / root canal
_____Hay fever
_____Sinusitis
_____Hearing loss
_____Recurrent ear infections
_____Ringing in ears
_____Sores in mouth / lips

RESPIRATORY

_____Asthma
_____Chronic cough
_____Recurrent bronchitis
_____Emphysema
_____Pneumonia
_____Shortness of breath

CARDIAC / CIRCULATION

_____Angina / Chest Pain
_____Cold hands / feet
_____Edema or swelling
_____Fainting
_____Leg pain with exercise
_____High / Low blood pressure
_____Palpitations

ABDOMINAL / DIGESTIVE

_____Difficulty swallowing
_____Abdominal bloating / pain
_____Irritable before meals
_____Pain before / after eating
_____Tired after eating
_____Distress from fatty foods
(Nausea, dizziness, headaches, etc.)
_____Food allergies
_____Hypoglycemia
_____Heartburn / reflux
_____Ulcers
_____Gallstones
_____Hepatitis / Liver disease
_____Hemorrhoids
_____Bleeding from rectum
_____Colitis
_____Constipation / Diarrhea
_____Change in bowel habits
_____Belching / Flatulence (gas)

GENITOURINARY

_____Bladder infections
_____Frequent urination
_____Kidney disease / stones
_____Venereal disease

HORMONAL

_____Diabetes
_____Goiter / Thyroid problems
_____Temperature sensitivity
_____Abnormal hair growth
_____Reduced sex drive

NEUROLOGIC

_____Childhood hyperactivity
_____Dizziness / Vertigo
_____Epilepsy / seizures
_____Weakness
_____Memory loss
_____Migraines / Headaches
_____Neuralgia / Neuritis
_____Concussions

MUSCULOSKELETAL

_____Arthritis / Joint pain
_____Osteoporosis
_____Sciatica / Low back pain
_____Muscle pain / fibromyalgia
_____Tendonitis / Bursitis
_____Fractures

PSYCHOLOGICAL

_____Depression / SAD
_____Anxiety
_____Mania
_____Nervous breakdown
_____Nightmares / Vivid dreams
_____Restless sleep / Insomnia
_____Sleep Apnea

DERMATOLOGIC

_____Brittle nails
_____Dandruff/dry scalp
_____Eczema or rash
_____Hives
_____Recurrent sores
_____Skin Cancer / mole changes

INFECTIOUS

_____Candida
_____Chickenpox / Shingles
_____Herpes I / II
_____Malaria
_____Measles / Mumps
_____Meningitis
_____Mononucleosis
_____Polio
_____Rheumatic / Scarlet fever
_____H. pylori
_____Tuberculosis

OTHER

_____Alcohol or drug abuse
_____Anemia
_____Bed wetting
_____Bruise / Bleeding tendency
_____Cancer / Leukemia
_____Weight problems / changes
_____Fatigue
_____Chemical sensitivities
_____ Known toxic exposures

FEMALES ONLY

Date of your last menstrual period: _____ Age of menopause? _____

How many days do your periods last? _____ Days in your monthly cycle? _____

Age you first began to menstruate?

Did you breast feed?

Do you perform self-breast exams?

Date of last mammogram:

Do you get a pap smear annually? ☐ YES ☐ NO Date of last exam _____

Number of miscarriages _____ / abortions _____ / still-births _____ / children _____

Current Ages of your children:

Any difficulty getting pregnant or complications of pregnancy (explain)?

Do you currently take birth control pills? ☐ YES ☐ NO

Did you ever take birth control pills? ☐ YES ☐ NO for how long _____

Current contraception used?

_____vaginal dryness / itching	_____abnormal Pap smears	_____decreased sex drive
_____vaginal discharge	_____problem periods	_____night sweats / hot flashes
_____pain with intercourse	_____PMS	_____breast discharge
_____breast tenderness	_____irregular bleeding	_____breast lumps or fibrocystic

MALES ONLY

Please check any problem that you now have or have ever had. Mark __C__ for current or __P__ if the problem was in the past.

_____Urine stream weak/slow	_____Nocturnal urination
_____Dribbling after urination	_____Premature ejaculation
_____Burning on urination	_____Swelling/lumps on testicles
_____Frequent or nocturnal urination	_____Loss of sexual interest function
_____Prostate problems	_____Loss of sexual function
_____Discharge from penis	_____Low sperm count or impotency

SOCIAL HISTORY

Do you eat:	**Yes**	**No**	**Serv./wk**
Meat	_____	_____	_____
Fish	_____	_____	_____
Fowl	_____	_____	_____
Dairy	_____	_____	_____
Eggs	_____	_____	_____
Refined Sugar	_____	_____	_____
Margarine	_____	_____	_____
Grains	_____	_____	_____
Veggies	_____	_____	_____
Fruit	_____	_____	_____

Water (# of glasses per day?) _____

Time of day you eat: Breakfast: _____
Lunch: _____
Dinner: _____
Late snack: _____

	Never	How Much / Often / Long	Quit
Cigarettes	_____	_____	_____
Chewing tob.	_____	_____	_____
Cigar	_____	_____	_____
Pipe	_____	_____	_____
Marijuana	_____	_____	_____
Rec. drugs	_____	_____	_____
Liquor	_____	_____	_____
Beer	_____	_____	_____
Wine	_____	_____	_____
Coffee	_____	_____	_____
Soft drinks	_____	_____	_____

Travel History

Have you traveled/lived outside the USA? Yes_ No_ If Yes, where: _____

Did you develop an illness as a result of your travels? _____

FAMILY HISTORY

Please list any family history of illness: **Adopted _____**

Father:

Mother:

Paternal Grandfather:

Paternal Grandmother:

Maternal Grandfather:

Maternal Grandmother:

Siblings:

Aunts, Uncles, Cousins:

Children:

EXTENDED ALLERGY HISTORY

Typical onset of symptoms: ☐ sudden ☐ progressive ☐ chronic ☐ fluctuates

CHECK MEDICATIONS YOU CURRENTLY TAKE

Prednisone
Actifed or Dimetapp (brompheniramine)
Atarax or Vistaril (hydroxyzine)
Benadryl (diphenhydramine)
Chlortrimeton (chlorpheniramine)
Allegra (fexofenadine)
Claritin (loratadine)
Clarinex (desloratadine)
Zyrtec (certirizine)
Phenergan (promethazine)
Singulair (montelukast)
Accolate (zafirlukast)
Zyflo (zileuton)
Tagament (cimetadine) or Zantac (ranitidine)
Pepcid (famotidine) or Axid (nizatidine)
Tavist (clemastine)
AllerChlor, Actifed, Bromfed, Drixoral, Dura-tab, Novafed-A, Ornade, Poly-Histine-D, Trinalin,

ANTIHISTAMINE NOT LISTED_____
BETA BLOCKERS _____
ANTIDEPRESSANTS_____
Any recent changes at home or work or diet?

SYMPTOMS EXPERIENCED

INFANTS:
_____ eczema or dermatitis
_____ cradle cap
_____ colic or always fussy
_____ frequent vomiting
_____ Burned Butt Syndrome
_____ frequent diaper rash
_____ poor sleeper
_____ does not smile
_____ hyperactive

MARK WHEN YOU HAVE SYMPTOMS:

W-Winter S-Spring Su-Summer F-Fall

EYES:
_____ allergic shiners or lines under eyes
_____ tearing
_____ swelling or angioedema
_____ redness

NOSE:
_____ Allergic nasal crease
_____ runny nose - clear
_____ nasal congestion or chronic mouth breathing
_____ pale intranasal mucosa
_____ dark, blue-purple nasal mucosa
_____ nasal polyps

EARS
_____ frequent ear infections
_____ red ears
_____ cracking of ear lobe/behind ear
_____ eczema of ear canal

MOUTH:
_____ inflammation of mucous membrane/tongue
_____ geographic tongue
_____ black hairy tongue

PHARYNX / NECK:
_____ post nasal discharge or drainage
_____ vascular injection
_____ itchy throat
_____ vocal cord swelling or inflammation
_____ enlarged tonsils
_____ enlarged lymphoid glands

LUNGS:
_____ coughing
_____ sneezing
_____ wheezing
_____ snoring
_____ hiccoughs

INTESTINAL:
_____ colitis
_____ belching, bloating after meals

URINARY:
_____ frequent bladder infections
_____ burning or pain with urination

SKIN:
_____ cracked nails - hands or feet
_____ severe itching - often continuous
_____ hives
_____ psoriasis

NEURO / PSYCH:
_____ chronic headaches/migraines
_____ mental confusion
_____ dizziness

ADDITIONAL:
_____ insomnia
_____ chronic Fatigue
_____ tired after 6-8 hours of sleep

EXTENDED ALLERGY HISTORY

Do you have a family history of allergy? ☐ Food ☐ Inhalant ☐ Mold/ Dust etc. ☐ Pollen

☐ Hives ☐ Itching ☐ Asthma ☐ Chemical Sensitivity Other _____

Does any member of your family have celiac (gluten sensitivity) or inflammatory bowel disease? _____

Are you currently receiving allergy injections? _____ For How long? _____

Are you under the direct care of an allergist?_____Direct care of another provider for allergies?_____

Do you have any allergies not under treatment? _____

Have you suffered from asthma in the past? _____Do you have wheezing now?_____

Do you suffer with gastro-intestinal problems?_____

Do you have food allergies? Please list:_____

Do you follow a special diet? Describe:_____

PREVIOUS ALLERGY TESTING:

Exposed to:	Testing Method:
☐ foods	☐ skin test (RAST)
☐ chemicals	☐ intradermal
☐ mold/dust/pollen	☐ blood panel
☐ pets	☐ elimination diet
☐ other	☐ other

DISCRIBE YOUR HOME ENVIRONMENT:

☐ House	☐ Residential	☐ Clean air
☐ Apartment	☐ Industrial	☐ Polluted air
☐ Mobile Home	☐ Freeway	☐ Mold
☐ Other	☐ Busy street	☐ Central
☐ Urban	☐ Old construct	☐ Filter units
☐ Suburban	☐ New construct	☐ Sunny
☐ Rural	☐ Insulation type	☐ Window

HEATING/AIR CONDITIONER AT WORK AND HOME:

☐ natural gas ☐ electric ☐ solar ☐ good ventilation

☐ oil heat ☐ fireplace ☐ pellet ☐ poor ventilation

☐ filters changed ☐ ducts cleaned

PETS: ☐ dog ☐ cat ☐ bird ☐ other _____

Do you know if you react to animals? _____

Which animals?_____

How?_____

HOME FURNISHINGS

☐ **Upholstery** ☐ cotton ☐ leather ☐ synthetic ☐ wool

☐ **Flooring** ☐ wood ☐ linoleum ☐ carpet, kind ☐ tile

☐ **Bedroom** ☐ carpet ☐ natural ☐ synthetic ☐ Feather

☐ **Cookware** ☐ stainless ☐ enamel ☐ glass ☐ teflon

☐ crock pot ☐ non-stick ☐ aluminum

Do you rotate foods: ☐ yes ☐ no

Do you use dietary supplements? ☐ yes ☐ no

DAILY / FREQUENT EXPOSURES:

☐ gas ☐ asphalt ☐ computer ☐ fluorescent lights

☐ auto exhaust ☐ diesel exhaust ☐ heavy equipment

☐ fly frequently ☐ new building ☐ pesticides/herbicides

☐ perfumes/aftershave ☐ make-up ☐ lotions

☐ nail products ☐ new fabrics ☐ mold

TRANSPORTATION: ☐ car ☐ bus ☐ walk ☐ bike

DO CHEMICALS OR ODORS MAKE YOU SICK?

How?_____

Which?_____

Have you ever had an anaphylactic reaction? ☐ yes ☐ no

If yes, what where you reacting to? _____

POSSIBLE ALLERGY RELATED CONDITIONS

(Please check any that apply to you)

☐ Unexplained fatigue or malaise

☐ Atopic Eczema

☐ Arthritis

☐ Ankylosing spondylitis

☐ Malnutrition

☐ Neuropsychiatric symptoms

☐ Carbohydrate Intolerance

☐ Abdominal Pain

☐ Flatulence

☐ Diarrhea

☐ Constipation

☐ Irritable Bowel Syndrome

☐ Crohn's or Ulcerative colitis

☐ Other inflammatory or autoimmune disorders

List your favorite, craved, or particularly enjoyed foods/beverage:

List foods that disagree with you and the symptoms they cause: