Patient Name: ______________________

PERSONAL MEDICAL HISTORY

Significant Illnesses:

☐ Cancer: __________	☐ Allergies	☐ Heart Disease	☐ Stroke
☐ Hepatitis: __________	☐ Asthma	☐ Herpes	☐ Thyroid Disease:
☐ Addictive Disorder: __________	☐ HIV (AIDS)	☐ High Blood Pressure	☐ Hyper ☐ Hypo
☐ Mental Illness: __________	☐ Diabetes	☐ Seizures	☐ Tuberculosis
☐ Venereal Disease: __________	☐ Other: __________		

Please check if you have experienced any of the following in the last 3 months:

General:

☐ Poor Appetite	☐ Fatigue	☐ Chills	☐ Insomnia
☐ Change in Appetite	☐ Sudden Energy Drop	☐ Fevers	☐ Emotional Changes
☐ Excessive Appetite	☐ Poor Balance	☐ Sweat Easily	
☐ Cravings: __________	☐ Localized Weakness	☐ Night Sweats	☐ Weight Gain
☐ Peculiar Tastes or Smells	☐ Tremors	☐ Bleeding	☐ Weight Loss
☐ Strong Thirst	☐ Joint Pain	☐ Bruise Easily	☐ Hearing Loss

Skin & Hair:

☐ Rashes	☐ Hives	☐ Acne	☐ Hair Loss
☐ Eczema	☐ Itching	☐ Recent Moles	☐ Dandruff
☐ Psoriasis	☐ Change in skin texture	☐ Ulcers	☐ Change in hair texture

Mouth, Ear, Nose, Throat & Eye:

☐ Dizziness	☐ Nose Bleeds	☐ Lip Sores	☐ Eye pain	☐ Night Blindness
☐ Earache	☐ Sinus Problems	☐ Mouth Ulcers	☐ Eye Strain	☐ Color Blindness
☐ Ear Infections	☐ Sore Throat	☐ Grinding Teeth	☐ Cataracts	☐ Spots in front of eyes
☐ Poor Hearing	☐ Gum Problems	☐ Jaw Click	☐ Glasses	☐ Floaters
☐ Ringing in Ears	☐ Toothache	☐ Facial Pain	☐ Glaucoma	☐ Blurred Vision

Respiratory:

☐ Cough	☐ Asthma	☐ Painful Breathing	☐ Bronchitis
☐ Coughing Blood	☐ Wheezing	☐ Easily Winded	☐ Recurrent Colds
☐ Phlegm	☐ Shortness of Breath		

Cardiovascular:

☐ Chest Pain	☐ Irregular Heart Beat	☐ Varicose Veins	☐ Swelling of Feet
☐ Palpitations	☐ High Blood Pressure	☐ Phlebitis	☐ Swelling of Hands
☐ Difficulty Breathing	☐ Low Blood Pressure	☐ Cold Sweats	☐ Cold Hands or Feet
	☐ Blood Clots	☐ Fainting	

Gastrointestinal:

☐ Nausea	☐ Bad Breath	☐ Bloating	☐ Black Stools	☐ Gastric Ulcers
☐ Vomiting	☐ Acid Regurgitation	☐ Constipation	☐ Blood in Stools	☐ Inguinal Hernia
☐ Belching	☐ Abdominal Pain	☐ Diarrhea	☐ Hemorrhoids	☐ Parasites
☐ Intestinal Gas	☐ Epigastric Pain			

Genito-Urinary:

☐ Painful Urination	☐ Frequent Night Urination	☐ Unable to Hold Urine	☐ Genital Sores
☐ Blood in Urine	☐ Urgent Urination	☐ Discolored Urine	☐ Impotence
☐ Frequent Urination	☐ Scanty Urine	☐ Kidney Stones	☐ Low Sex Drive
			☐ High Sex Drive