Patient's Initials: _____ _____ _____

Medical History Form

Name:			**Date:**
Date of Birth:	**Gender:** ❑ **M** ❑ **F**	**Age:**	**Ethnicity:** ❑ **Hispanic/Latino** ❑**Non-Hispanic/Latino**

Race: ❑ **White** ❑ **Black or African American** ❑ **Asian** ❑ **American Indian or Alaska Native** ❑ **Native Hawaiian or Other Pacific Islander**

Blood Pressure:	**Blood Pressure:**	**Blood Pressure:**	**Pulse:**
Height: _____ in.	**Weight:** _____ lb.	**BMI:** _____kg/m^2	

Occupation:	
Primary Care Physician:	**Other Physician:**
Reason For Visit:	**Onset of Symptoms:**
Current Treatment:	**Prior Treatment:**

Family History

		If Living		If Deceased	
	Sex	**Age**	**Health/Medical History**	**Age at Death**	**Cause of Death**
Father	M				
Mother	F				
Brothers / Sisters					
	M / F				
	M / F				
	M / F				
	M / F				
Husband / Wife					
Sons / Daughters					
	M / F				
	M / F				
	M / F				
	M / F				

Drug Allergies / Reaction:
Non-Drug Allergies / Reaction:
Seasonal Allergies / Reaction:

Patient's Initials: _____ _____ _____

Please mark "yes" to all conditions that apply and include the date and medications you are taking for the condition.

Disease / Syndrome	Yes	No	Start Date:	Resolved Date:	Medications/Supplements
Gastrointestinal System				**(Check box if ongoing)**	
❑GERD ❑Acid Reflux ❑Heartburn	❑	❑		❑	
Indigestion/Dyspepsia	❑	❑		❑	
Ulcer: (Type):_____	❑	❑		❑	
Gallstones	❑	❑		❑	
Pancreatitis	❑	❑		❑	
❑ Constipation ❑ Diarrhea	❑	❑		❑	
Irritable Bowel Syndrome	❑	❑		❑	
Diverticulosis	❑	❑		❑	
Colon Polyps	❑	❑		❑	
Other:	❑	❑		❑	
Hepatic / Liver				**(Check box if ongoing)**	
❑ Hepatitis A ❑ Hepatitis B ❑ Hepatitis C	❑	❑		❑	
Cirrhosis	❑	❑		❑	
Fatty Liver Disease	❑	❑		❑	
Other:	❑	❑		❑	
Genitourinary				**(Check box if ongoing)**	
Urination Problem (specify):_____	❑	❑		❑	
Urinary Tract Infection	❑	❑		❑	
❑ Kidney Stones ❑ Kidney Disease	❑	❑		❑	
Enlarged Prostate ❑ NA	❑	❑		❑	
Erectile Dysfunction ❑ NA	❑	❑		❑	
Uterine Fibroids ❑ NA	❑	❑		❑	
Endometriosis ❑ NA	❑	❑		❑	
Low Libido / Sex Drive	❑	❑		❑	
Other:	❑	❑		❑	
Hematological				**(Check box if ongoing)**	
Anemia	❑	❑		❑	

Patient's Initials: _____ _____ _____

Disease / Syndrome	Yes	No	Start Date:	Resolved Date:	Medications/Supplements
Vitamin B12 Deficiency	❑	❑		❑	
Vitamin D Deficiency	❑	❑		❑	
Other:	❑	❑		❑	
Eyes, Ears, Nose, and Throat				**(Check box if ongoing)**	
Glaucoma	❑	❑		❑	
Cataracts	❑	❑		❑	
❑ Nearsighted ❑ Farsighted	❑	❑		❑	
Macular Degeneration	❑	❑		❑	
Retinopathy	❑	❑		❑	
Hearing Loss	❑	❑		❑	
Other:	❑	❑		❑	
Neurological				**(Check box if ongoing)**	
Headaches	❑	❑		❑	
Migraines	❑	❑		❑	
Mini-Stroke (TIA)	❑	❑		❑	
Stroke	❑	❑		❑	
Seizures	❑	❑		❑	
Head Injury	❑	❑		❑	
Tremors	❑	❑		❑	
Carpal Tunnel Syndrome ❑Right ❑ Left	❑	❑		❑	
Diabetic Neuropathy ❑Hands ❑ Feet	❑	❑		❑	
Sciatica	❑	❑		❑	
Vertigo	❑	❑		❑	
Other:	❑	❑		❑	
Respiratory				**(Check box if ongoing)**	
COPD/Emphysema	❑	❑		❑	
Asthma	❑	❑		❑	
Sleep Apnea	❑	❑		❑	
Oxygen Dependent	❑	❑		❑	
Other:	❑	❑		❑	

Patient's Initials: _____ _____ _____

Disease / Syndrome	Yes	No	Start Date:	Resolved Date:	Medications/Supplements
Dermatology				(Check box if ongoing)	
Acne	❑	❑		❑	
Rosacea	❑	❑		❑	
Rashes	❑	❑		❑	
Eczema	❑	❑		❑	
Psoriasis	❑	❑		❑	
Skin Cancer: Location:_____ ❑ Squamous ❑ Basal ❑ Melanoma	❑	❑		❑	
Fungus: Location:_____	❑	❑		❑	
Other:	❑	❑		❑	
Musculoskeletal				(Check box if ongoing)	
Arthritis: Osteoarthritis	❑	❑		❑	
Arthritis: Rheumatoid	❑	❑		❑	
Arthritis: Psoriatic	❑	❑		❑	
Muscle Spasms	❑	❑		❑	
Fibromyalgia	❑	❑		❑	
Gout	❑	❑		❑	
❑Osteopenia ❑Osteoporosis	❑	❑		❑	
Back Pain	❑	❑		❑	
Bone Injuries	❑	❑		❑	
Other:	❑	❑		❑	
Endocrine / Metabolic				(Check box if ongoing)	
Diabetes: ❑ Type I or ❑ Type II	❑	❑		❑	
High Cholesterol	❑	❑		❑	
High Triglycerides	❑	❑		❑	
Thyroid: ❑ Hypo (Underactive) ❑ Hyper (Overactive)	❑	❑		❑	
Overweight	❑	❑		❑	
Other:	❑	❑		❑	
Neoplasia				(Check box if ongoing)	

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Cancer (Type):_____	❑	❑		❑	
Disease / Syndrome	**Yes**	**No**	**Start Date:**	**Resolved Date:**	**Medications/Supplements**
Cardiovascular			**(Check box if ongoing)**		
High Blood Pressure (Hypertension)	❑	❑		❑	
Irregular Heart Beats	❑	❑		❑	
❑Pacemaker ❑Defibrillator ❑Other	❑	❑		❑	
Heart Failure	❑	❑		❑	
Heart Attack	❑	❑		❑	
❑ Heart Catheter ❑ Stent	❑	❑		❑	
Coronary Artery Disease	❑	❑		❑	
Carotid Artery Disease	❑	❑		❑	
Poor Circulation in the Legs ❑ PAD ❑ PVD	❑	❑		❑	
Chest Pain (Angina) ❑ Resting ❑ With Exertion	❑	❑		❑	
Swelling (Edema) in lower extremities: ❑ Rt. Foot ❑ Lt. Foot ❑ Rt. Leg ❑ Lt. Leg ❑ Chronic ❑ Intermittent	❑	❑		❑	
Other:	❑	❑		❑	
Infectious Disease			**(Check box if ongoing)**		
HIV	❑	❑		❑	
Other:	❑	❑		❑	
Autoimmune Disease			**(Check box if ongoing)**		
Lupus	❑	❑		❑	
Multiple Sclerosis	❑	❑		❑	
Sjögren's Syndrome	❑	❑		❑	
Other:	❑	❑		❑	
Psychiatric			**(Check box if ongoing)**		
Anxiety	❑	❑		❑	
Depression	❑	❑		❑	
Insomnia	❑	❑		❑	
Bipolar Disorder	❑	❑		❑	
Schizophrenia	❑	❑		❑	

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Memory Loss	❑	❑		❑	
Other:	❑	❑		❑	

Surgical History (Include elective surgeries as well):

PROCEDURE	REASON FOR PROCEDURE	DATE OF PROCEDURE

Personal Habits

Do you have a history of tobacco use? ❑ Current ❑ Former ❑ Never

Type: ❑ Cigarettes ❑ Smokeless ❑ Pipe ❑ Cigars | **Quantity per day_____ Years smoked_____ Year quit_____**

Do you have a history of recreational drug use? ❑ Current ❑ Former ❑ Never

Do you have a history of alcohol abuse? ❑ Current ❑ Former ❑ Never

On average, how many alcoholic drinks do you consume weekly?

For Women Only

Can you still have children? ❑ Yes ❑ No

When was your last period? _____ (Month/Year)

If Yes, What do you use for birth control? (List 2 Methods)

_____

If No ❑ Post-Menopausal

❑ Surgically Sterile: (Select One):

❑ Tubal Ligation ❑ Hysterectomy ❑ Ovaries Removed

Notes:

Patient Signature: _____ Date: _____

Study Coordinator Signature: _____ Date: _____