

Personal History

Name: _____

Date: _____

Have you ever had or do you have any of the following:	No	Yes	Details of "Yes" answers. (identify item)
Allergies to drugs / medications / saccharin / Nutrasweet			
Pneumonia			
Pleurisy			
Rheumatic fever			
Heart disease			
Back trouble			
Arthritis			
Any bone / joint disease			
Hair loss			
Anemia			
Jaundice			
Epilepsy			
Seizure			
Migraine headaches			
Lung trouble-Asthma / Emphysema			
Diabetes			
Concussion / Head injury			
Food allergies			
Dietary restrictions			
Chemical poisoning			
Drug poisoning			
Food poisoning			
Have you ever had or do you have any of the following:			
Blood Pressure ____ High ____ Low			
Nervous breakdown			
Hives			
Eczema			
Any other disease			
WOMEN ONLY - Menstrual History	No	Yes	Details of "Yes" answers. (identify item)
Do you have periods?			
Regular ____ Heavy ____ Medium ____ Light ____			
Experience tension or depression before or during periods?			
Cramps/pain with periods			
Hot flashes			
Are you currently breast feeding?			
REVIEW OF SYSTEMS			
Have you ever had/have any of the following	No	Yes	Details of "Yes" answers. (identify item)
Eye disease or impaired sight			
Impaired hearing			
ANY TROUBLE WITH:			
Nose			
Sinuses			
Mouth			
Throat			
Bleeding gums			
Light headedness			
Convulsions			
Dizziness			
Paralysis			
Headaches: ____ Frequent ____ Severe			
Enlarged glands			
Thyroid: ____ Overactive ____ Underactive ____ Enlarged ____			
Goiter			
Cough: ____ Frequent ____ Chronic			
Chest Pain			
Angina pectoris			
Palpitations or Rapid pulse			
Spitting up blood			
Neightsweats			
Shortness of breath ____ Exertion ____ At night			
Leg cramps			

Patient's Signature _____

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	No	Yes	Details of "Yes" answers. (identify item)
Swelling of: ___ Hands ___ Feet ___ Ankles			
Extreme tiredness or weakness			
Kidney disease			
Kidney stones			
Blood in urine ___ Albumin ___ Sugar ___ Pus in urine			
Abnormal thirst			
Stomach trouble			
Liver disease			
Liver disease			
Gallbladder disease			
Gall stones			
Colitis			
Other bowel disease			
Hemorrhoids			
Rectal bleeding			
Black tarry stools			
Constipation			
Diarrhea			
Any eating disorder			
Anorexia			
Bulimia			
Excessive use of laxatives			
HABITS - DO YOU:	No	Yes	Details of "Yes" answers. (identify item)
Exercise adequately			
Awaken rested			
Sleep well			
Have regular bowel movements			
Like your work (___ hrs. per day)			
Have you ever been treated for alcoholism or drug abuse			
DO YOU USE:	No	Yes	Details of "Yes" answers. (identify item)
Laxatives - How often?			
Vitamins			
Sedatives, stimulants, other drugs			
Tranquilizers			
Sleeping pills, etc.			
Cortisone			
Alcoholic beverages			
Coffee (___ Cups per day)			
Tobacco products _____ amount			
Appetite suppressants (diet pills)			
HAVE YOU EVER TAKEN:	No	Yes	Details of "Yes" answers. (identify item)
Insulin			
Tablets for diabetes			
Hormone shots			
Hormone tablets			

List any surgeries you have had and the date performed:

WEIGHT - Now ___ Weight one year ago ___			
Maximum: _____ Date: _____			
Your weight at age 16 _____ 20 _____ 30 _____			
Amount gained last 3 months _____ 6 months _____			
Have you reduced in the past?			
With medicine			
With diet program			
Do you skip meals?			

If patient is under 18 years of age, parent or legal guardian please sign authorization for treatment.

Date _____ Patient's Signature: _____

Date: _____ Physician's Signature: _____