

Medical History & Conditions



PERSONAL INFORMATION

Name: _____ DOB: _____ Gender: M F

Home Address: _____ City: _____ State: _____ Zip: _____

Check Primary Phone

Phone: Home _____ Cell _____ Work _____

E-mail: _____ FAX: _____

Occupation: _____

Emergency Contact: Name: _____ Relationship: _____

Address: _____ Phone: _____

Primary Physician: Name: _____

Address: _____

Phone: _____ FAX: _____ E-mail: _____

FAMILY HISTORY

	Illnesses	Age at Death	Cause of Death
Father			
Mother			
Siblings <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F			

MEDICATIONS

Medication and Indication for Use	Dose/Frequency	Strength	Method	Start Date	Stop Date

ALLERGIES

Medications	Describe Reaction	Year

LIFESTYLE

If Yes, please describe type, amount and frequency:

Nicotine	<input type="checkbox"/> No <input type="checkbox"/> Yes	#	Packs per Day, for	years.
Alcohol	<input type="checkbox"/> No <input type="checkbox"/> Yes	#	Drinks per Day, for	years.
Exercise	<input type="checkbox"/> No <input type="checkbox"/> Yes			

HOSPITALIZATIONS, SURGERY, PROCEDURE, INJURIES

Description	Year	Description	Year

SYMPTOMS & CONDITIONS

	Year Started	Year Ended		Year Started	Year Ended
<input checked="" type="checkbox"/> Check all that Apply			<input checked="" type="checkbox"/> Check all that Apply		
GENERAL			Glaucoma		
Allergies, Environmental			Goiter		
Insomnia			Hearing Loss		
Overweight			Recurrent Sinus Infections		
Fatigue			Thyroid Nodule		
Other:			Tinnitus [Ringing in Ears]		
EYES, EARS, NOSE, THROAT			Change in Vision		
Cold Sores			Voice Change or Hoarseness		
Cataracts			Other:		

Medical History & Conditions

Name: _____

-----If condition is continuing, please write C -----

√	Check all that Apply	Year Started	Year Ended	√	Check all that Apply	Year Started	Year Ended
	RESPIRATORY				ENDOCRINE/METABOLIC		
	Asthma				Diabetes		
	COPD				High Cholesterol		
	Dyspnea [Shortness of Breath]				High Triglycerides		
	Emphysema				Thyroid Disease		
	Obstructive Sleep Apnea				<i>Other:</i>		
	Pneumonia						
	Recurrent Bronchitis				NEUROLOGICAL		
	Tuberculosis				Carpal Tunnel Syndrome		
	<i>Chronic Cough</i>				Diabetic Neuropathy		
	<i>Other:</i>				Headaches (Tension/Stress)		
	CARDIOVASCULAR				Migraine Headaches w/o Aura		
	Angina (Chest Pain)				Migraine Headaches w/ Aura		
	Arrhythmia (Irregular Heart Beat)				Paralysis		
	Edema (Swelling of Feet)				Seizure Disorder		
	Heart Attack				Stroke		
	Heart Failure				Vertigo (dizziness)		
	Heart Murmur				<i>Other:</i>		
	High Blood Pressure				MENTAL HEALTH		
	Venous Thrombosis (Clots)				Anxiety		
	Varicose Veins				Bipolar Disorder		
	<i>Pain in Calves or Thighs with Walking</i>				Depression		
	<i>Other:</i>				<i>Other:</i>		
	GASTROINTESTINAL				MUSCULOSKELETAL		
	Gall stones				Gout		
	GERD (Reflux/Heartburn)				Low Back Pain		
	Hepatitis				Osteoarthritis		
	Irritable Bowel Syndrome				Osteoporosis		
	Liver Disease				Neck Pain		
	Ulcer Disease				Rheumatoid Arthritis		
	<i>Other:</i>				<i>Joint Tenderness</i>		
	URINARY				<i>Joint Stiffness</i>		
	Hematuria (Blood in Urine)				<i>Limitation of Joint Movement</i>		
	Kidney Stones				<i>Other:</i>		
	Recurrent UTIs (Infections)				SKIN		
	Urinary Incontinence (Leaking Urine)				Dermatitis		
	<i>Increased Nighttime Urination</i>				Eczema		
	<i>Other:</i>				Hives		
	FEMALES				Psoriasis		
	Age at Menopause				<i>Other:</i>		
	Breast Disease				BLOOD		
	Irregular Periods				Anemia		
	Menopausal Symptoms				Blood Donor		
	Polycystic Ovarian Syndrome				Phlebitis		
	Last Mammogram Date:				<i>Other:</i>		
	Last Pap Smear Date:				CANCER		
	<i>Vaginal Discharge</i>				Breast Cancer		
	<i>Other:</i>				Cervical Cancer		
	MALES				Leukemia/Lymphoma		
	Hernias				Melanoma		
	Prostate Enlargement				Skin Cancer		
	Sexual Difficulties				<i>Other:</i>		
	<i>Other:</i>						

Study Participant's Signature:
(Upon completion or updating of form, sign & date next available line)

Medical Provider's Signature: _____

Completed by: _____ Date: _____

Reviewed by: _____ Date: _____

Updated by: _____ Date: _____

Reviewed by: _____ Date: _____

Updated by: _____ Date: _____

Reviewed by: _____ Date: _____

Updated by: _____ Date: _____

Reviewed by: _____ Date: _____

Updated by: _____ Date: _____

Reviewed by: _____ Date: _____