Medical History Data Form

Please circle yes or no if you or an immediate family member have been told you have:	Self	Self		Family	Family
Cancer	Yes	No		Yes	No
Diabetes	Yes	No		Yes	No
High Blood pressure	Yes	No		Yes	No
Heart disease	Yes	No		Yes	No
Angina/ chest pain	Yes	No		Yes	No
Stroke	Yes	No		Yes	No
Osteoporosis	Yes	No		Yes	No
Osteoarthritis	Yes	No		Yes	No
Rheumatoid arthritis	Yes	No		Yes	No

In the past 3 months have you had or do you experience:	**YES**		**NO**
A change in your health?	Y		N
Nausea/vomiting?	Y		N
Fever/ Chills/ Sweats?	Y		N
Unexplained weight change?	Y		N
Numbness or tingling?	Y		N
Changes in appetite?	Y		N
Difficulty swallowing?	Y		N
Changes in bowel or bladder function?	Y		N
Shortness of breath?	Y		N
Dizziness?	Y		N
Upper respiratory infection?	Y		N
Urinary tract infection?	Y		N
Change in your balance? (Falls?)	Y		N

Do you have a history of	**YES**		**NO**
Allergies/ asthma?	Y		N
Headaches?	Y		N
Bronchitis?	Y		N
Kidney disease?	Y		N
Rheumatic fever?	Y		N
Ulcers?	Y		N
Sexually transmitted disease?	Y		N
Seizures?	Y		N
Are you currently:	Y		N
Pregnant?	Y		N
Depressed?	Y		N
Under stress?	Y		N

Circle the most appropriate answer				
Are your symptoms:	Getting worse	The same	Improving	
How are you able to sleep at night	Fine	Moderate difficulty	Only with medication	
Do you have a problem with	Hearing	Vision	Speech	Communication
My symptoms are worse in the	Morning	Afternoon	Evening	Night
My symptoms are best in the	Morning	Afternoon	Evening	Night

Do you or have you in the past smoked tobacco? Y N
If YES: how many per day, for how many years? ________________________________
Last tobacco use: ____

Do you drink alcoholic beverages? Y N
If YES: how many drinks do you routinely have per week? ___________

Date of last physical examination:________________________

Patient Name: ______________________________ Date:_________________

Please attach medication list as necessary, thank you.