Past Medical History

Patient name: ____________________

Please complete this form. The purpose of this questionnaire is to help us perform a thorough evaluation and understand your condition.

Please note that this form is considered part of your medical records and will be kept private and confidential.

Have you ever suffered from or been told that you have:			
High blood pressure	Yes	No	
Heart problems	Yes	No	
Lung problems	Yes	No	
Head Injury	Yes	No	
Multiple Sclerosis / Parkinson's Disease	Yes	No	
Stroke / Neurological problems	Yes	No	
Liver problems	Yes	No	
Thyroid problems	Yes	No	
Blood disorders (inc. high sedimentation rates)	Yes	No	
Diabetes (high blood sugar)	Yes	No	
Low blood sugar	Yes	No	
Cancer	Yes	No	
Arthritis	Yes	No	
Osteoporosis	Yes	No	
Circulation or vascular problems	Yes	No	
Broken bones (fractures)	Yes	No	
Other orthopedic problems	Yes	No	
Chronic pain	Yes	No	
Ulcers / stomach problems	Yes	No	
For men only:	Yes	No	
◦ Prostate disease	Yes	No	
For women only:	Yes	No	
◦ Pelvic inflammatory disease	Yes	No	
◦ Endometriosis	Yes	No	
◦ Have you had complicated pregnancies	Yes	No	
◦ Trouble with your period	Yes	No	
◦ Are you pregnant, or think you might be pregnant?	Yes	No	

Have you recently experienced:			
Weight loss / gain	Yes	No	
Pain at night	Yes	No	
Fatigue / tiredness or malaise	Yes	No	
Difficulty sleeping	Yes	No	
Joint pain and /or swelling	Yes	No	
Urinary or bowel problems	Yes	No	
Nausea and vomiting	Yes	No	
Numbness or tingling (where?)	Yes	No	
Weakness in your arms or legs	Yes	No	
Coordination problems	Yes	No	
Difficulty walking	Yes	No	
Dizziness or loss of consciousness	Yes	No	
Loss of balance	Yes	No	
Chest pain	Yes	No	
Heart palpitations	Yes	No	
Shortness of breath	Yes	No	
Difficulty swallowing	Yes	No	
New onset of headaches	Yes	No	
Visual problems	Yes	No	
Hearing problems	Yes	No	
Do you			
Smoke	Yes	No	
◦ If yes, how much? ______ Ppd			
Drink alcohol	Yes	No	
◦ If so, how much?			
Have any significant family history of illness or disease	Yes	No	
Have any other medical problems	Yes	No	

Have you had surgery or been hospitalized in the past? Yes No
Reason and date of incident:

☐ ______________________________
☐ ______________________________
☐ ______________________________

Who is your primary physician or the doctor you see the most?

____

How were you referred to us?

☐ Doctor ______________________________
☐ Friend/ Prior patient ______________________________
☐ Insurance Company ______________________________
☐ Our Website ______________________________
☐ Yellow Pages ______________________________
☐ Other ______________________________