INTEGRATIVE
HEALTH & HEART

COMPLETE MEDICAL HISTORY FORM

Name: ___________________________________ **Date of Birth:** _______________ **Age:** _________

SOCIAL HISTORY

Please Circle One: Single Married Divorced Widowed

How many children do you have? (Please include ages): _______________________________

How many pets do you have? ____

Occupation:____

Hobbies:____

Exercise (type, frequency): ____

Tobacco (type, length of time, packs per day, frequency, second hand smoke exposure):

____

Alcohol (type, frequency): ____

Caffeine (type, frequency): ____

Illicit Drugs (type, frequency, past usage): ____

PAST MEDICAL HISTORY

Please list any medical problems you have had (blood pressure, cholesterol, diabetes, mental health, gynecological issues, skin or joint issues, etc.):

- ____
- ____
- ____
- ____
- ____
- ____
- ____
- ____

SURGERIES/HOSPITALIZATIONS/TESTS/PROCEDURES

- **Year:** **Reason:**____
- **Year:** **Reason:**____
- **Year:** **Reason:**____
- **Year:** **Reason:**____
- **Year:** **Reason:**____

MEDICATIONS

Please include prescription medications, Over the Counter (OTC) medications, and Herbal Supplements:

- ____
- ____
- ____
- ____
- ____
- ____
- ____
- ____

ALLERGIES

Please list all medications, foods, or environments to which you are allergic, and the reactions experienced:

- **Allergic:**___________ **Reaction:**_____________________________________
- **Allergic:**___________ **Reaction:**_____________________________________
- **Allergic:**___________ **Reaction:**_____________________________________
- **Allergic:**___________ **Reaction:**_____________________________________

OB/GYN HISTORY (if applicable)

- **Periods began (age):**
- **Menopause (age):**
- **Pregnant (# times):**
- **Live births (#):**
- **Misc./Abortions (#):**
- **Abnormal Paps (Year):**

PREVENTATIVE MEDICINE

Please enter the date when the following tests or exams were performed:

- **General PE:**
- **Dental:**
- **Eyes:**
- **EKG:**
- **Stress test:**
- **Hearing test:**
- **Pap:**
- **Other**
- **Mammogram:**
- **Bone density:**
- **Prostate check:**
- **Colonoscopy:**
- **Flu:**
- **Tetanus:**
- **Hepatitis A/B:**
- **Chickenpox:**
- **MMR:**
- **Meningitis:**
- **Shingles:**
- **Pneumonia:**

FAMILY HEALTH HISTORY

Relationship	Current Age(s)	Age at Death(s)	Known Health Problems
Mother			
Father			
Brother(s)			
Sister(s)			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunt(s)			
Maternal Uncle(s)			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunt(s)			
Paternal Uncle(s)			

PREVIOUS MEDICAL PROVIDERS

Name of Physician or Practice	Phone #	Specialty

REVIEW OF SYSTEMS

Please check any conditions you have experienced recently:

GENERAL

☐ Weight gain ☐ Decreased Appetite ☐ Night Sweats ☐ Weight Loss
☐ Chills ☐ Increased Appetite ☐ Weakness ☐ Fever
☐ Fatigue ☐ Other: ____________________

HEAD, EYES, EARS, NOSE THROAT

☐ Eye pain ☐ Wear glasses/contacts ☐ Eye discharge
☐ Halos (optical phenomenon) ☐ Hearing loss ☐ Ear fullness
☐ Ear discomfort ☐ Ringing/buzzing in ears ☐ Ear discharge
☐ Sinus issues ☐ Wear dentures/partials ☐ Difficulty swallowing
☐ Persistent hoarseness ☐ Sore gums ☐ Toothaches
☐ Jaw pain ☐ Dry mouth ☐ Sores in mouth
☐ Bloody nose ☐ Nasal congestion ☐ Double vision
☐ Other: ____________________

CARDIOVASCULAR

☐ Chest pain at rest ☐ Chest pain with exertion ☐ Irregular heart rhythm ☐ Ankle swelling
☐ Passing out ☐ Leg cramps with walking ☐ Palpitations/rapid heart beat
☐ Other:____________________

LUNGS

☐ Persistent cough ☐ Sputum production ☐ Coughing up blood ☐ Wheezing
☐ Shortness of breath ☐ Chronic infections ☐ Difficulty breathing when lying flat
☐ Other: ____________________

HEMATOLOGY

☐ Prolonged bleeding ☐ Bruising easily ☐ Blood Transfusions ☐ Transfusion reaction
☐ Other: ____________________

SKIN

☐ Dry skin ☐ Skin infection ☐ Hair changes ☐ Nail changes
☐ Rash ☐ Open sores ☐ Itchy skin ☐ Skin Lesions
☐ Other: ____________________

MALE GENITALIA

☐ Penis Discharge ☐ Penis Sores ☐ Testicular Mass ☐ Impotence
☐ Other: ____________________

FEMALE GENITALIA

☐ Vaginal Bleeding ☐ Pelvic Pain ☐ Painful Intercourse ☐ Vaginal Discharge/Itching
☐ Other: ____________________

GASTROINTESTINAL

☐ Abdominal pain ☐ Vomiting blood ☐ Heartburn ☐ Constipation
☐ Bloating/Gas ☐ Black/Tarry stool ☐ Hemorrhoids ☐ Bloody stool
☐ Diarrhea ☐ Food intolerance ☐ Nausea/Vomiting ☐ Loose stool
☐ Difficult to swallow ☐ Change in bowel habits
☐ Other: ____

URINARY

☐ Frequent urination ☐ Pain/Burning with urination ☐ Blood in urine
☐ Difficulty starting urination ☐ Kidney/Bladder infections ☐ Difficulty emptying bladder
☐ Decrease in urinary stream ☐ Frequent Nocturnal Urination ☐ Excessive urination
☐ Urine leakage with cough/sneeze/laugh ☐ Urinary urgency (difficulty making it to restroom)
☐ Other: ____

MUSCULOSKELETAL

☐ Frequent Falls ☐ Brittle bones ☐ Back pain ☐ Muscle weakness
☐ Joint pain ☐ Joint stiffness ☐ Joint swelling ☐ Muscle aches
☐ Difficulty walking
☐ Other: ____

ENDOCRINE

☐ Intolerance to heat ☐ Intolerance to cold ☐ Excessive thirst ☐ Excessive hunger
☐ Other: ____

BREASTS

☐ Masses/Lumps ☐ Bleeding ☐ Pain ☐ Change in size/shape ☐ Nipple discharge
☐ Other: ____

NEUROLOGIC

☐ Frequent headaches ☐ Dizziness ☐ Stroke or stroke symptoms
☐ Difficulty speaking ☐ Fainting/Blacking out ☐ Paralysis
☐ Memory difficulties ☐ Tremor ☐ Sleep difficulties
☐ Feeling sad/lonely ☐ Nervous/anxiety ☐ Psychiatry treatment
☐ Numbness/Unusual sensation in arms and legs ☐ Loss of interest in usual activities
☐ Other: ____

INTEGRATIVE
HEALTH & HEART

Please list any medical concerns not previously addressed:

____
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____
____
____
____
____
____
____
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____
____
____
____

A Medical Records Release form may need to be completed if the physician deems necessary. These records include (but not limited to): progress notes, operative notes, laboratory test results, diagnostic tests results, and any imaging results.