



Place for Achieving Total Health
 304 Park Avenue South, 6th Floor, New York, NY 10010

MEDICAL HISTORY

NAME _____ **DATE** _____

CONSTITUTIONAL

Good general health YES NO
 Recent weight change YES NO
 Fever YES NO
 Fatigue YES NO
 Headaches YES NO
 Night sweats YES NO

EYES

Eye disease or injury YES NO
 Wear glasses / contact lens YES NO
 Blurred/double vision YES NO
 Glaucoma YES NO
 Floaters YES NO
 Loss of vision YES NO
 Inability to focus YES NO

ENT

Hearing loss YES NO
 Snoring YES NO
 Ringing in the ears YES NO
 Sinus problems YES NO
 Nose bleeds, congestion, pain YES NO
 Mouth sores, pain YES NO
 Bleeding gums YES NO
 Bad breath or bad taste YES NO
 Sore throat or voice change YES NO
 Swollen glands in neck YES NO
 Pain in ears YES NO

CARDIOVASCULAR

Heart trouble YES NO
 Chest pain YES NO
 Sudden heart beat change YES NO
 Swelling of feet, ankles or hands YES NO
 Shortness of breath YES NO
 Lightheadedness YES NO

RESPIRATORY

Frequent coughing YES NO
 Spitting up blood YES NO
 Shortness of breath YES NO
 Asthma or wheezing YES NO
 Chest pain YES NO
 Sputum production YES NO

GASTROINTESTINAL

Loss of appetite YES NO
 Change in bowel movement YES NO
 Nausea or vomiting YES NO
 Frequent diarrhea YES NO
 Painful bowel movements / constipation YES NO
 Blood in stool YES NO
 Stomach pain YES NO
 Black stool YES NO
 Heartburn YES NO
 Difficulty swallowing YES NO
 Last Colonoscopy and findings _____

GENITOURINARY

Frequent urination YES NO
 Burning or painful urination YES NO
 Blood in urine YES NO
 Change of force of strain when urinating YES NO
 Incontinence or dribbling YES NO
 Kidney stones YES NO
 Male – testicle pain/swelling YES NO
 Female – pain with periods YES NO
 Female – irregular periods YES NO
 Female –vaginal discharge YES NO
 Female – # pregnancies _____ # miscarriages _____
 Female –Last PAP Smear and findings _____
 Female – Last Mammogram and findings _____
 Changes in sexual functioning YES NO
 Breast tenderness, discharge, lumps YES NO
 Genital sores YES NO

MUSCULOSKELETAL

Joint pain YES NO
 Joint stiffness or swelling YES NO
 Weakness of muscles or joints YES NO
 Muscle pain or cramps YES NO
 Back pain YES NO
 Cold extremities YES NO
 Difficulty in walking YES NO
 Loss of muscle mass YES NO
 Involuntary painless muscle movement YES NO
 Difficulty rising from a low chair YES NO
 Difficulty negotiating stairs YES NO

SKIN

Dry Skin YES NO
 Rash or itching YES NO
 Change in skin color YES NO
 Change in hair or nails YES NO
 Varicose veins YES NO
 Skin lesions/moles YES NO

NEUROLOGICAL

Frequent or recurring headaches YES NO
 Light headed or dizzy YES NO
 Convulsions or seizures YES NO
 Numbness or tingling sensations YES NO
 Tremors YES NO
 Paralysis YES NO
 Stroke YES NO
 Loss of balance YES NO
 Loss of strength YES NO
 Falls YES NO
 Loss of consciousness YES NO
 Difficulty speaking YES NO

PSYCHIATRIC

Memory loss or confusion YES NO
 Nervousness YES NO
 Depression YES NO
 Sleep problems YES NO
 Panic attacks YES NO
 Suicidal thoughts / ideation YES NO

ENDOCRINE

Glandular or hormone problem YES NO
 Thyroid disease YES NO
 Excessive thirst or urination YES NO
 Heat or cold intolerance YES NO
 Dry skin YES NO
 Change in hat or glove size YES NO
 Excessive hair growth YES NO
 Darkening of the skin YES NO

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts YES NO
 Easily bruise or bleed YES NO
 Anemia YES NO
 Phlebitis YES NO
 Past transfusion YES NO
 Enlarged glands YES NO
 Excessive bleeding YES NO

List any MEDICATIONS you are CURRENTLY taking:

 Patient's Signature _____
 Name of person completing history if other than patient:
