PATIENT PAST HISTORY FORM

Patient # _____

Name: _____ **Date:** _____

Please check **ANY** symptoms you are experiencing NOW or have experienced in the PAST, even if they do not seem related to your current complaint.

MUSCULOSKELETAL

- o Neck Problems
- o Low Back Problems
- o Pain Between Shoulders
- o Arm, Shoulder, Hand Pain
- o Leg, Knee, Foot Pain
- o Sciatica
- o Swollen Joints
- o Painful Joints
- o Stiff Joints
- o Sore Muscles
- o Weak Muscles
- o Walking Problems
- o Broken Bones

NERVOUS SYSTEM

- o Numbness
- o Pins & Needles
- o Paralysis
- o Dizziness
- o Fainting
- o Headaches
- o Muscle Spasms
- o Convulsions
- o Forgetfulness
- o Confusion
- o Nervousness
- o Depression

GENITOURINARY

- o Lost Control of Urination
- o Frequent Urination
- o Painful Urination
- o Discoloured Urine
- o Kidney Troubles
- o Prostate Troubles

SKIN

- o Skin conditions_____

GASTROINTESTINAL

- o Poor Appetite
- o Excessive Hunger
- o Difficulty Chewing
- o Difficulty Swallowing
- o Difficult Digestion
- o Colon Troubles
- o Excessive Thirst
- o Nausea
- o Vomiting
- o Vomiting Blood
- o Abdominal Pain
- o Diarrhea
- o Constipation
- o Black or Bloody Stool
- o Hemorrhoids
- o Liver Troubles
- o Gall Bladder Troubles

CARDIOVASCULAR

- o Chest Pain
- o Pain Over Heart
- o Shortness of breath
- o Chronic Cough / Wheezing
- o Bronchitis
- o Asthma
- o Emphysema
- o Throat Phlegm
- o Rapid Heart Beats
- o High Cholesterol
- o High Blood Pressure
- o Low Blood Pressure
- o CCHF
- o Heart Disease
- o Heart Attack
- o Stroke / CVA
- o Phlebitis
- o Pacemaker / Similar Device
- o Lung Problems
- o Varicose Veins

EYE, EAR, NOSE, THROAT

- o Eye Strain
- o Eye Inflammation
- o Vision Loss / Problems
- o Crossed Eyes
- o Ear Pain / Aches
- o Ear Noises
- o Hearing Loss
- o Ear Discharge
- o Sinus Infections
- o Allergies / Hay fever
- o Enlarged Glands / Thyroid
- o Nose Pain
- o Nose Bleeds
- o Nose Discharge
- o Nasal Obstruction
- o Sore / Bleeding Gums
- o Dental Problems: Last Exam_____
- o Hoarseness
- o Difficult Speech

FOR WOMEN ONLY

- o Cramps
- o Heavy Flow
- o Light Flow
- o Irregular Cycle
- o Painful Cycle
- o Discharge
- o Sore Breasts
- o Menopausal?
  - o Age at Onset:_____
- o Miscarriages: _____
- o Endometriosis: _____
- o Pregnant? Due Date:_____

INFECTIONS/ DISEASE

- o Hepatitis _____
- o TB
- o HIV
- o Cancer Type:_____

Habits of Lifestyle:

Do you Smoke? Yes / No

Do you Consume Alcohol? Yes / No

Do you Exercise? Yes / No

If Yes, describe_____

Rate your sleep: Hours / Night: 4-6 6-8 8-10 12+ Do you wake rested? Yes / No

Rate your Diet: Poor Fair Medium Good Excellent How many meals / day?_____

Rate your Overall Health: Very Good Good Adequate Poor Very Poor

Please List **ALL** medications, vitamins, minerals or supplements you take:_____

_____

Please List Any Hospitalizations & Surgeries:_____

Please List Any Family Health Conditions:_____

Any Other Health / Medical Concerns (i.e.: digestive conditions gynecological conditions, etc): _____

_____