PATIENT PAST HISTORY FORM

Name: _____ Date: _____

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

C = Constant F = Frequent O = Occasional

NEUROLOGICAL

C	F	O	
☐	☐	☐	allergy
☐	☐	☐	chills
☐	☐	☐	convulsions
☐	☐	☐	dizziness
☐	☐	☐	fainting
☐	☐	☐	fevers
☐	☐	☐	headaches
☐	☐	☐	loss of sleep
☐	☐	☐	nervousness
☐	☐	☐	depression
☐	☐	☐	neuralgia
☐	☐	☐	numbness
☐	☐	☐	sweats
☐	☐	☐	loss of weight
☐	☐	☐	tremors

MUSCLES & JOINT

☐	☐	☐	arthritis
☐	☐	☐	bursitis
☐	☐	☐	foot trouble
☐	☐	☐	hernia
☐	☐	☐	low back pain
☐	☐	☐	neck pain
☐	☐	☐	neck stiffness
☐	☐	☐	pain between shoulders

RESPIRATORY

☐	☐	☐	chest pain
☐	☐	☐	chronic cough
☐	☐	☐	difficulty breathing
☐	☐	☐	spitting blood
☐	☐	☐	throat phlegm
☐	☐	☐	wheezing

EYES, EARS, NOSE & THROAT

☐	☐	☐	colds
☐	☐	☐	crossed eyes
☐	☐	☐	deafness
☐	☐	☐	dental decay
☐	☐	☐	asthma
☐	☐	☐	ear aches
☐	☐	☐	ear discharges
☐	☐	☐	ear noises
☐	☐	☐	sinus infections
☐	☐	☐	enlarged glands
☐	☐	☐	enlarged thyroid
☐	☐	☐	sore throat
☐	☐	☐	tonsillitis
☐	☐	☐	eye pain
☐	☐	☐	failing vision
☐	☐	☐	far sighted
☐	☐	☐	gum trouble
☐	☐	☐	hay fever
☐	☐	☐	hoarseness
☐	☐	☐	nasal obstruction
☐	☐	☐	near sighted
☐	☐	☐	nosebleeds

CARDIOVASCULAR

☐	☐	☐	rapid heartbeat
☐	☐	☐	slow heartbeat
☐	☐	☐	swelling of ankles
☐	☐	☐	hardening of arteries
☐	☐	☐	high blood pressure
☐	☐	☐	low blood pressure
☐	☐	☐	pain over heart
☐	☐	☐	poor circulation

GASTRO INTESTINAL

☐	☐	☐	excessive hunger
☐	☐	☐	burping or gas
☐	☐	☐	liver trouble
☐	☐	☐	colitis
☐	☐	☐	colon trouble
☐	☐	☐	constipation
☐	☐	☐	diarrhea
☐	☐	☐	difficult digestion
☐	☐	☐	distention of abdomen
☐	☐	☐	stomach pain
☐	☐	☐	gall bladder trouble
☐	☐	☐	hemorrhoids
☐	☐	☐	intestinal worms
☐	☐	☐	jaundice
☐	☐	☐	poor appetite
☐	☐	☐	nausea
☐	☐	☐	vomiting
☐	☐	☐	vomit blood

SKIN

☐	☐	☐	boils
☐	☐	☐	bruise easily
☐	☐	☐	dryness
☐	☐	☐	hives or allergy
☐	☐	☐	itching
☐	☐	☐	skin rash
☐	☐	☐	varicose veins

GENITO-URINARY

☐	☐	☐	bed wetting
☐	☐	☐	blood in urine
☐	☐	☐	frequent urination
☐	☐	☐	loss control urine
☐	☐	☐	kidney infection
☐	☐	☐	painful urination
☐	☐	☐	prostate trouble
☐	☐	☐	pus in urine
☐	☐	☐	smell of urine

PAIN OR NUMBNESS IN:

☐	☐	☐	shoulders
☐	☐	☐	arms
☐	☐	☐	hands
☐	☐	☐	hips
☐	☐	☐	legs
☐	☐	☐	knees
☐	☐	☐	ankles
☐	☐	☐	feet
☐	☐	☐	painful tail bone
☐	☐	☐	sciatica
☐	☐	☐	swollen joints

FOR WOMEN ONLY

☐	☐	☐	cramps
☐	☐	☐	heavy flow
☐	☐	☐	light flow
☐	☐	☐	irregular cycle
☐	☐	☐	painful cycle
☐	☐	☐	discharge
☐	☐	☐	sore breasts

Menopausal: Yes No

Last menstruation date:_____

Pregnant: Yes No

Due date: _____

PATIENT PAST HISTORY FORM (continued)

HABITS OF LIFESTYLE:

Do you smoke: ☐ Yes ☐ No Do you consume alcohol: ☐ Yes ☐ No

Do you exercise: ☐ Yes ☐ No Exercise Indoor Activities: _____

Exercise Outdoor Activities: _____

Rate your sleep hours per night: 4-6 6-8 8-10 12+

Do you wake rested: ☐ Yes ☐ No

Rate your appetite: Poor Fair Medium Good Excellent

Rate your diet: Poor Fair Medium Good Excellent

Do you eat regularly: Breakfast Lunch Dinner

Do you eat per day: 1 meal 2 meals 3 meals 4 meals More than 4 meals

Date of last Dental Examination: _____

Falls and Accidents – list: _____

_____

Surgery and Operations – list: _____

_____

Surgery recommended but not performed – list: _____

_____

Do you take vitamins and minerals? List: ☐ Yes ☐ No

_____

Have you ever been knocked unconscious: ☐ Yes ☐ No ☐ Don't Know

If so, for how long: _____

List any medication or drugs you are currently taking: _____

_____

Have you previously been hospitalized: ☐ Yes ☐ No

Please list: _____

Any family health conditions or problems: ☐ Yes ☐ No

Please list: _____

Signature: _____ Date: _____