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Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

Review of medical history:

Check if any of the below applied to you at any time in your life:

Ringing in Ears___ Peptic Ulcer___ Convulsions/Seizures___ Ear Infections___ Abdominal Pain-Chronic___ Stroke___ Dizziness/Fainting___ Gall Bladder Trouble___ Tremors___ Hair Loss___ Jaundice/Hepatitis___ Muscle Weakness___ Failing Vision___ Change in Bowel Habits___ Numbness/Tingling___ Eye Infections___ Diarrhea___ Constipation___ Frequent Headaches___ Nose Bleeds___ Diverticulitis___ Crohn's___ Colitis___ Arthritis/Rheumatism___ Sinus Trouble___ Bloody or Tarry Stools___ Osteoporosis___ Frequent Sore Throats___ Hemorrhoids___ Back Pain___ Hay Fever/Allergies___ Hernia___ Bone Fractures/Joint Injury___ Frequent Urine Infections___ Gout___ Bronchitis/Chronic Cough___ Foot Pain___ Cold Numb Feet___ Asthma/Wheezing___ Rash___ Hives___ Eczema___ Psoriasis___ Phobias___ Nervousness___ Depression___ Mental Illness___ High Blood Pressure___ Kidney Stones___ Memory Loss___ Chronic Fatigue___ Varicose Veins___ Recent Weight Loss___ Heart Murmur___ Venereal Disease___ Excessive Moodiness___ Swollen Ankles___ Urethral Discharge___ Chest Pain___ Walking Pain___ Loss of Appetite___ Anemia___ Bruise Easily___ Difficulty Swallowing___ Cancer: Date: ___ Where: ___ Indigestion/Heartburn___ Diabetes___ Frequent Nausea/Vomiting___ Thyroid Disease___ Diphtheria___	<b>RECENT INJECTIONS:</b> Tetanus___ Chicken Pox___ Measles___ Rubella___ Scarlet Fever___ Others_____  <b>FEMALE ONLY:</b> Pregnant?___ Planning?___ Last menstrual flow date___ Regular___ Irregular___ No. days of flow___ Pain with or after sex? ___ No. of Pregnancies? ___ No. of Births? ___ Miscarriages___ Birth Control___  Date of Last Pap? ___ Frequent Infection___
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**URINATION:** Blood in Urine\_\_\_ How Often? \_\_\_ Overnight Urination-How many times per night? \_\_\_  
 Painful Urination\_\_\_ Loss of Control\_\_\_ How Often? \_\_\_ Decrease of Force/Flow\_\_\_

**FAMILY HISTORY** Does your father, mother, children, siblings or grandparents have or had any of these medical problems?

ALCOHOLISM _____	HIGH BLOOD PRESSURE _____
ASTHMA _____	KIDNEY DISEASE _____
BLEEDING DISORDER _____	MENTAL ILLNESS _____
CANCER _____	MIGRAINES _____
DIABETES _____	OSTEOPORSOSIS _____
GLAUCOMA _____	STROKE _____
HEART DISEASE _____	THYROID DISEASE _____
OTHERS _____	

Do you drink alcohol? \_\_\_\_\_ How often? \_\_\_\_\_ Do you smoke? \_\_\_\_\_ How much? \_\_\_\_\_  
 What approx. is your salt intake? \_\_\_\_\_ Fat intake? \_\_\_\_\_ Caffeine intake? \_\_\_\_\_  
 Do you exercise? \_\_\_\_\_ How often? \_\_\_\_\_