Past Medical History

Patient name:_____

Please complete this form. The purpose of this questionnaire is to help us perform a thorough evaluation and further understand your condition.
Please note that this form is considered part of your medical records and will be kept private and confidential.

Have you ever suffered or have been told that you have:			
High blood pressure	**YES**	**NO**	
Heart problems	**YES**	**NO**	
Lung problems	**YES**	**NO**	
Head injury	**YES**	**NO**	
Multiple sclerosis/Parkinson's Disease	**YES**	**NO**	
Stroke	**YES**	**NO**	
Liver problems	**YES**	**NO**	
Thyroid problems	**YES**	**NO**	
Blood disorders	**YES**	**NO**	
Diabetes (high blood sugar)	**YES**	**NO**	
Low blood sugar	**YES**	**NO**	
Cancer	**YES**	**NO**	
Arthritis	**YES**	**NO**	
Osteoporosis	**YES**	**NO**	
Circulatory or vascular problems	**YES**	**NO**	
Broken bones (fractures)	**YES**	**NO**	
Other orthopedic problems	**YES**	**NO**	
Chronic pain	**YES**	**NO**	
Ulcers/stomach problems	**YES**	**NO**	
Chronic migraines	**YES**	**NO**	
For men only:			
• Prostate disease	**YES**	**NO**	
For women only:			
• Pelvic inflammatory disease	**YES**	**NO**	
• Endometriosis	**YES**	**NO**	
• Complicated pregnancies	**YES**	**NO**	
• Trouble with your period	**YES**	**NO**	
• Are you currently pregnant?	**YES**	**NO**	
PLEASE TURN OVER			**PLEASE TURN OVER**

Have you recently experienced:			
Weight loss/gain	**YES**	**NO**	
Pain at night	**YES**	**NO**	
Fatigue/malaise	**YES**	**NO**	
Difficulty sleeping	**YES**	**NO**	
Joint pain and/or swelling	**YES**	**NO**	
Urinary or bowel problems	**YES**	**NO**	
Nausea and vomiting	**YES**	**NO**	
Numbness or tingling, if yes where?	**YES**	**NO**	
Weakness in your arms or legs	**YES**	**NO**	
Coordination problems	**YES**	**NO**	
Difficulty walking	**YES**	**NO**	
Dizziness or loss of consciousness	**YES**	**NO**	
Chest pain	**YES**	**NO**	
Heart palpitations	**YES**	**NO**	
Shortness of breath	**YES**	**NO**	
Difficulty swallowing	**YES**	**NO**	
New onset of headaches	**YES**	**NO**	
Visual problems	**YES**	**NO**	
Hearing problems	**YES**	**NO**	
Do you:			
Smoke	**YES**	**NO**	
• If yes, how much?_____ppd			
Drink alcohol	**YES**	**NO**	
• If yes, how much?_____			
Have any significant family history of illness or disease	**YES**	**NO**	
Other			

Have you had surgery or been hospitalized in the past? YES NO
Date/reason :_____
_____

Who is the primary physician that you see most often?_____

How were your referred to us? (Please check) Doctor □ _____
Friend/prior patient□_____ Insurance company □ Internet □
Yellow Pages □ Other□_____