# TAKING A QUICK MEDICAL HISTORY

Name: _____ Date: _____

Do you experience any of the following symptoms? If so, rate each of the following symptoms based upon your typical health profile.

4 = Frequently have it, effect is severe
3 = Frequently have it, effect is not severe.
2 = Occasionally have it, effect is severe
1 = Occasionally have it, effect is not severe
0 = Never or almost never have the symptom

1. Digestive:

_____ Constipation
_____ Diarrhea or loose stool
_____ Gas
_____ Belching
_____ Bloating
_____ Poor digestion
_____ Abdominal pain
_____ White, coated tongue
_____ Heartburn
_____ Indigestion
_____ Bad breath

2. Head, emotions, and mind:

_____ Headaches
_____ Depression
_____ Anxiety
_____ Fear
_____ Nervousness
_____ Irritable or angry easily
_____ Become aggressive easily
_____ AFly off the handle@
_____ Reduced memory
_____ Reduced concentration
_____ Head pressure
_____ Difficulty thinking clearly
_____ Mood swings
_____ Difficulty in making decisions
_____ Confusion
_____ Poor comprehension
_____ Learning difficulties or learning disabilities
_____ Hyperactivity
_____ Restlessness
_____ Insomnia
_____ Drowsiness
_____ Have seen psychologist

3. Energy activity:

_____ Tire easily/fatigue/low level of energy
_____ Wake up tired
_____ Tired by the end of the day
_____ Sleep excessively
_____ Feel excessively cold
_____ Weight gain

4. Skin:

_____ Feel excessively cold
_____ Cold hands
_____ Cold feet
_____ Dry skin
_____ Acne
_____ Rashes

5. Muscles/Joints:

_____ Muscle aches/muscle pain/muscle spasms; where: forearms, fingers, thighs, legs/feet, neck generalized (encircle all that apply)
_____ Muscle cramps/charley horses
_____ Low back pain/spasm
_____ Pain/tightness in upper back
_____ Pain/tightness in neck, shoulder area (encircle all that apply).
_____ Joint pains, where: Shoulders, elbows, wrists, hands, hips, knees, ankles, foot, multiple joints (encircle all that apply).

6. Cardiovascular:

_____ High blood pressure
_____ Rapid heartbeat / irregular heartbeat
_____ Have seen cardiiologist
_____ Irregular or skipped heartbeat
_____ Palpitations

7. Nose

_____ Stuffy nose
_____ Runny nose
_____ Hay fever
_____ Sniffles
_____ Sneezing attacks
_____ Postnasal drip
_____ Sinus infections

8. Lungs

_____ Wheezing
_____ Asthma
_____ Difficulty in breathing
_____ Chest tightness
_____ Chest congestion
_____ Shortness of breath
_____ Chronic cough

9. Urinary tract:

_____ Frequent urination
_____ Burning on urination
_____ Awaken at night to urinate

10. FOR WOMEN ONLY: Female reproductive system:

_____ Have ever had vaginal yeast infection. If yes, total number of yeast infections in your lifetime _____.
_____ Vaginal discharge
_____ Premenstrual symptoms, a few to several days before menstruation. If yes, what premenstrual symptoms do you have?
_____ Premenstrual headaches
_____ Premenstrual depression
_____ Premenstrual irritability
_____ Premenstrual anxiety
_____ Premenstrual bloating
_____ Premenstrual fluid retention
_____ Other premenstrual symptoms (please specify)
_____

11. FOR BOTH MEN AND WOMEN: Have you ever been diagnosed with any of the following? (Check T what applies to you.)

_____ Hypothyroidism (low thyroid).
_____ Goiter (enlarged thyroid)
_____ High cholesterol
_____ High triglycerides
_____ Diabetes
_____ Hypoglycemia
_____ Fibromyalgia
_____ Mitral valve prolapse
_____ Irritable bowel syndrome
_____ Gallstones
_____ Alcoholism
_____ Drug abuse
_____ Endometriosis (women)
_____ Fibrocystic breast (women).

12. Do you smoke? _____ Yes _____No

13. Do any of the following odors bother you? Check T those odors that bother you.

_____ Tobacco smoke
_____ Exhaust fumes
_____ Bleaches
_____ Detergents
_____ Ammonia
_____ Asphalt
_____ Tar
_____ Mothballs
_____ Insect sprays
_____ Paints
_____ Varnishes
_____ Perfumes
_____ Hair sprays
_____ Cosmetics
_____ Gasoline products
_____ Natural gas
_____ Furniture polish
_____ Floor wax
_____ Newsprint
_____ New fabric stores
_____ Odors of any kind

14. Do foods bother you or disagree with you, including alcohol? _____Yes _____No
Explain:

15. Do you crave or over-consume sugar, bread, chocolate, colas, or alcohol? _____Yes _____No

16. Do you get sleepy, tired, have indigestion, or any other symptoms after meals or after certain foods? ___Yes ___No. Explain:

17. Are you allergic to any medicines? _____ Yes _____No

18. List medicines you are currently taking:

19. Effect of illness:

a. How many days out of the month are your good days, i.e., when you feel perfectly fine and nothing seems to bother you? _____ Days of the month
b. How many days out of the month are your bad days, i.e., when your symptoms bother you? _____ Days of the month
c. How are these symptoms bothersome for you, i.e., how are they interfering with your daily activities, family life, or career? If you need more space, add an additional page.