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PATIENT MEDICAL SELF-HISTORY

Name___________________________________ **Date of Birth**_____________ **Today's date**________________

What is the chief complaint for which you are seeking treatment today? When and how did it begin?

____

____

MEDICAL HISTORY. Please indicate below *IF YOU CURRENTLY OR HAVE EVER HAD* any of:

CONDITIONS	Date of onset and present status
Cancer	
HIV+/AIDS	
Implants or prosthetics	
Pacemaker or de-fibrillator	
Irregular heartbeat, arrythmias, valve prolapse	
Epilepsy	
Spinal fracture or cord injury	
Bone fractures: where?	
Blood clots: where?	
Osteoporosis/osteopenia	
Pregnancy	
Bleeding Disorder	
Sensory loss: where?	
Fainting spells	
Anemia	
High blood pressure	
Low blood pressure	
Hypoglycemia	
Diabetes *circle type I II*	
Compromised immunity/ immuno-suppressive medications	
Hepatitis *circle A B C D E*	
Tuberculosis	

Please circle below any and all of the following symptoms that you *CURRENTLY* have:

General. Weight loss Weight gain General weakness Fatigue or drowsiness Fever Headache Dizziness Abnormal sweating Swelling Cramps Difficulty sleeping Moodiness Irritability Depression Anxiety Panic Attacks Obsessive thoughts or habits Memory loss Confusion Difficulty concentrating Eating disorders Loss of motivation

Muskuloskeletal & Nuerologic. Muscle pains Joint or bone pains Nerve pains Limited range-of-motion Muscle weakness Paralysis Numbness or tingling sensations Tremors or involuntary movements

Cardiovascular and pulmonary. Heart disease Chest pain Uncomfortable heartbeat or murmurs Asthma Bronchitis Emphysema Pneumonia Wheezing Difficult/painful breathing Cough Bloody sputum

Gastrointestinal. Trouble swallowing Reflux Bloating Abdominal pain Loss of appetite Change in thirst Nausea Vomiting Vomiting blood Black, tarry, or bloody stool Diarrhea, urgent stool, loss of bowel control Food intolerance Hemorrhoids Constipation

PLEASE COMPLETE ON REVERSE

Name__________________________________ Date of Birth_____________ Today's date________________

Urinary and Reproductive. Change in frequency of urination Burning, pain, dribbling, hesitancy on urination Urinary urgency Nocturnal urination Bloody or discolored urine Urinary incontinence Perineal numbness or tingling Hernias Menstrual difficulty, pain

Skin and Lymphatic. Rashes Lumps Sores Dryness Itching New moles or growths Change in mole or growth

Head/Eyes/Ears/Nose/Throat. Vision changes or difficulty Ear ringing Hearing changes or difficulty Vertigo Frequent colds or flus Nasal discharge or bleeding Sinus/nasal problems

Endocrine. Thyroid disorders Parathyroid disorders Other endocrine disorders: ____

PLEASE LIST ANY OTHER COMPLAINTS OR KNOWN MEDICAL CONDITIONS NOT INDICATED ABOVE:
____
____

Please list any surgical operations you have had, with approximate dates:
1. ____
2. ____
3. ____
4. ____

Please list any medications that you take on a regular basis, along with dosages:
1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Please list any known allergens, including foods, herbs and nutritional supplements, medications, and environmental:
____

What exercise do you get, how often? ____
How is your sleep quality and quantity? What hours do you typically sleep? ____________________________
____
Please describe your typical dietary habits:
Breakfast ____
Lunch and snacks ____
Dinner, desserts ____
Alcohol, tobacco, recreational drug use: ____

Please list any major medical conditions and causes of death (if any) in immediate family:
Mother:____
Father:____
Siblings:____

The above information regarding my medical history is, to the best of my knowledge, complete and accurate. I agree to promptly inform Anthony Von der Muhll, L.Ac., of any changes in my health status and/or additional medical history.

Patient name (please print) ____
Patient signature____ Date _______________
Guardian or interpreter signature________________________________ Date______________