NW HEADACHE AND WELLNESS CENTER

MEDICAL HISTORY FORM

(5 PAGES TOTAL)

Patient Name: _____ **Today's Date:** _____

Medication List

list ALL medications, including those prescribed by another doctor, and all over-the-counter medications such as Tylenol, Vitamins, herbals, creams, lotions and drops. This helps ensure your continuing quality health care.

PLEASE BRING ALL OF YOUR MEDICATIONS/SUPPLEMENTS TO YOUR APPOINTMENT SO WE CAN ACCURATELY IDENTIFY DOSAGES

Current Medications: (Name, Dosage and Milligrams, Days/Week)	**Previous Medications (Name, Dosage and Milligrams, Days/Week)**

Notes: _____

Patient Name: _____ **Date of Birth:** _____

Primary Dr. _____ **Referring Dr.** _____

Occupation: _____

WT		**P**	
HT		**R**	
BP		**T**	

For Doctor's use

Please list the names of other providers (w/ their specialty) you have seen in the past year (including physicians, naturopaths, chiropractors, acupuncturists, counselors, psychiatrists, physical therapists):

_____

_____

_____

What is the main reason for your visit today? (Briefly explain specific symptoms, how symptoms started and what happened):

_____

_____

PAST MEDICAL HISTORY

Do you have, or have you had in the past, any of the following conditions (please circle):

ADD/ADHD	Cancer _____	High Blood Pressure	Rheumatoid /Osteoarthritis
Allergies	Depression	High Cholesterol	Seizure Disorder
Anxiety	Diabetes	Kidney Disease	Sexually Transmitted
Arnold Chiari Malformation	Fainting	Kidney Stones	Stroke
Asthma	Heart Attack	Multiple Sclerosis	Thyroid Disease
Autoimmune Disease	Heart Disease	Osteoporosis	Tuberculosis
Bipolar	Hepatitis	Renal Failure	Ulcers

Please list any prior injuries or accidents and their dates:

_____

_____

SURGICAL HISTORY:

Please list any surgeries you have had with the dates they were performed:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Have you ever had a head or neck CT or MRI performed on you? Yes No

(If so, when and where?) _____

Patient Name: _____ **Date of Birth:** _____

ALLERGIES:

Have you ever had a reaction to any medication? If so, which medication and what happened:

_____

Are you allergic to any food, plants or animals? If yes, please explain:

_____

Are you on a special diet? If yes, please explain:

_____

FAMILY HISTORY:

Are there illnesses such as epilepsy, cancer, diabetes, heart disease, high blood pressure or depression that run in your family? Yes No

Health status of your family:

Relationship:	**Living:**	**Age:**	**Significant Health Problems:**
Mother	Y N	____	_____
Father	Y N	____	_____
Sibling	Y N	____	_____
Sibling	Y N	____	_____
Sibling	Y N	____	_____
Paternal Grandfather	Y N	____	_____
Paternal Grandmother	Y N	____	_____
Maternal Grandfather	Y N	____	_____
Maternal Grandmother	Y N	____	_____
Child	Y N	____	_____
Child	Y N	____	_____
_____	Y N	____	_____
_____	Y N	____	_____
_____	Y N	____	_____
_____	Y N	____	_____
_____	Y N	____	_____

Patient Name: _____ **Date of Birth:** _____

WELLNESS QUESTIONS:

Do you…

Currently smoke tobacco? Y N If yes, how much? _____ For how long? _____

Have you smoked in the past? Y N If yes, how much? _____ How long? _____ Last Quit date? _____

Do you drink alcohol? Y N If yes, how much? _____ How often per month?

Drink caffeinated beverages? Y N If yes, how much? _____

Use recreational "street drugs" (including marijuana, cocaine, ecstasy, LSD, methamphetamine)

Y N If yes, what type? _____ How much? _____

Ever inject drugs? Y N If yes, how much? _____

Do you wear a seatbelt? Y N If yes, how often? _____

Are you sexually active? Y N If yes, with men? _____ with women? _____ both? _____

Travel outside the US? Y N If so, where? _____

Where were you born? _____

Describe your sleep quality: Excellent Average Poor

If not excellent, please explain why this may be the case: _____

Do you exercise? Y N If yes, describes your exercise program and how often you do this:

_____

_____

Do you skip meals? Y N If yes, how often and at what time of day:

Do you pray? Y N Do you meditate? Y N

Do you have any stress-reduction skills you use regularly? Y N If yes, please describes:

_____

_____

How many glasses of water do you drink each day? _____

How happy are you: Very Moderately Somewhat Very Unhappy

Please explain further: _____

_____

WOMEN:

Date of last Menses? _____ Birth Control method: _____

Is your period predictable? Y N If no, how long has it been this way? _____

Number of pregnancies: _____ Number of births: _____

Number of miscarriages: _____ If yes, in what trimester did this occur? _____

Patient Name: _____ **Date of Birth:** _____

REVIEW OF SYSTEMS:

Please circle any that apply to you or write in any symptoms that are not listed:

General: fever, chills, night sweats, snoring, restless legs, weakness, weight loss, anxiety, anger, fatigue, sadness, poor concentration

Eyes: blurry vision, double vision, irritation, redness, vision loss, excessive tearing, wear glasses or contacts

Ears, Nose, Throat: ear pain, ringing or popping in ears, decreased hearing, nasal congestion, wax in ears, nose bleeds, sore throat

Cardiovascular: chest pain, heart disease, fast/slow heart rate, light headedness, palpitations, shortness of breath with walking, difficulty, sleeping flat, leg or ankle swelling

Respiratory: cough, shortness of breath at rest, excessive phlegm, bloody phlegm, asthma, chest pain with taking a deep breath, pneumonia, wheezing

Gastrointestinal: nausea, vomiting, diarrhea, constipation, change in bowel habits, abdominal pain, blood in stool, blood in vomit, jaundice, gas, bloating, ulcers, hernia, difficulty swallowing, indigestion/heartburn, hemorrhoids

Muscles and Joints: back pain, joint pain, joint swelling, muscle cramps or pain, muscle weakness, arthritis, fractures, dislocations, sprains, cold or blue/white fingers or toes

Neurologic: burning, tingling, seizures, tremors, dizziness, fainting spells, frequent falls, frequent headaches, memory loss, difficulty walking, blurry vision or double vision

Psychological: depression, anxiety, ADD/ADHD, phobias, confusion, bipolar, post-traumatic stress disorder

Endocrine: cold intolerance, heat intolerance, excessive thirst, excessive urination, unusual weight change, excessive hair growth or hair loss

Skin: rash, itching, dryness, redness, flaky scalp, skin cancer, moles

Blood: abnormal bruising, abnormal bleeding, anemia, enlarged/swollen glands, recurrent infections

Allergy: postnasal drip, sneezing, itchy eyes, skin, nose or throat, rashes

For Men: painful urination, blood in urine, penile discharge, urinary frequency, urinary hesitancy, abnormal urine stream, waking often to urinate, loss of urine with cough or straining, testicular pain or swelling, difficulty achieving or maintaining erections, pain with ejaculation, premature ejaculation, history of sexually transmitted disease

For Women: cysts on ovaries, endometriosis, heavy cycles, irregular cycles, pain with menses, loss of urine with cough, laughing hard or straining, painful urination, blood in urine, urinary frequency, pain or bleeding with intercourse, history of abnormal pap smear, history of sexually transmitted disease, vaginal discharge, uterine ablation, hysterectomy (partial or full)

Other: _____