

PERSONAL MEDICAL HISTORY FORM

*Please describe any and all dental work done:
(fillings, filling removal, root canals, crowns, surgeries, mercury fillings (how many) etc.)*

Nervous System:

Paralysis	Attention Deficit Disorder	Convulsions	“Wired” feeling
Drug Addiction	Autistic Spectral Disorder	Burning Sensations	Depression
Hyperactivity	Tremors	Loss of Sleep	Panic Attacks
Brain Fog	Forgetfulness	Nervousness	Anger Issues
Fainting	Numbness in hands/fingers	Anxiety	

Gastrointestinal:

Poor Appetite	Ulcers	Gallbladder Trouble	Jaundice
Excessive Appetite	Hiatal Hernia	Vomiting	Hepatitis
Gas/Bloating	Heartburn	Stomach Cramps	Frequent Nausea
Fatigue after eating	Liver Trouble	Hemorrhoids	Diarrhea
Constipation	Colon Trouble	Weight trouble(loss/gain)	

Cardiovascular/Respiratory:

Hardening of Arteries	Poor Circulation	Spitting up Blood	Pleurisy
Chest Pain/Angina	Varicose Veins	Short of Breath	Emphysema
Irregular Heartbeat	Ankle Swelling	Difficulty Breathing	Pneumonia
Heart Problems	Cold Hands/Feet	Asthma	Chronic Cough

Genito-Urinary:

Bed Wetting	Bladder Infections	Discharges	Kidney Stones
Frequent Urination	Kidney Infections	Venereal Disease	Other STD
Excessive Urination	Discolored Urine	Genital Herpes	

Endocrine/Hematology:

Anemia	Diabetes Adult/Child	Pituitary Gland Trouble
Thyroid Gland Trouble	Hypoglycemia/Low Blood Sugar	Adrenal Problems

Female only:

Date last PAP	Regular Menstrual Cycles? Y/N	Premenstrual Tension
Date last Mammogram	Pregnant? Y/N	Menstrual Cramps/Backache
Date last period began	Number of Pregnancies	Excessive Flow
Period Length	Number of births	Vaginal Discharge
Hysterectomy Total/Partial	Contraception type	Menopause Age
Cycle length	Self-Breast Exams? Y/N	Sexually Transmitted Disease

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Male only:

Prostate Problems	Dribbling of Urine	Urgency to Urinate	Other
Retention of Urine	Sexual Dysfunction	Loss of Libido	Pain

Breast (Male & Female)

Breast pain	Breast lumps	Discharge	Swelling
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List all surgeries, hospitalizations (age and date):

Family History:

- *Have any blood relatives had any of the following:*
- *Cancer, TB, Diabetes, Hypoglycemia, Heart Trouble, Allergies, Blood Pressure Problems,*
- *Kidney Disease, Alcoholism, Nervous or Mental Disorder, or Genetic problems?*

Father	Age	Mother	Age	Brother	Age	Sister	Age

List DRUGS & supplements you are taking:

The following is important in helping the doctor determine how your life style may affect your health.

Type of Employment/work	
Hours of work per day/week	
Job Role	
Do you Exercise Yes/No Describe	
Please describe sleep habits	
Leisure activities	

Give a brief summary of all significant emotional traumas & phobias:

Thank you for your time in filling in this form..