PATIENT REGISTRATION AND HISTORY

SYSTEM REVIEW

*Mark symptoms that **you have Now** (during the **past 6 months**). **Circle symptoms that are worsening.** Circle **F** if 'frequent' (>1x/week).*

GENERAL
- ☐ Aches – persistent F
- ☐ Agitation/ Anger F
- ☐ Appetite loss F
- ☐ Bruise easily F
- ☐ Chills F
- ☐ Clumsiness F
- ☐ Dizziness / Fainting F
- ☐ Excessive hunger F
- ☐ Excessive thirst F
- ☐ Feel cold F
- ☐ Feel hot F
- ☐ Fever (recent) F
- ☐ Forgetfulness F
- ☐ Frequent colds/ illness F
- ☐ Headache F
- ☐ Infection (recent) _____ F
- ☐ Mood swings/ Irritability F
- ☐ Muscle cramps F
- ☐ Muscle twitches F
- ☐ Nausea F
- ☐ Nervousness F
- ☐ Nocturnal (night) pains F
- ☐ Numbness/ tingling F
- ☐ Seizures F
- ☐ Sleeping difficulty F
- ☐ Stiffness F
- ☐ Tiredness/ fatigue F
- ☐ Tremor/ shaking F
- ☐ Vertigo F
- ☐ Weakness F
- ☐ Weight loss (abnormal) F
- ☐ Weight gain (abnormal) F

DIGESTIVE
- ☐ Abdominal pain F
- ☐ Bloating F
- ☐ Blood – rectal or stools F
- ☐ Bowel changes F
- ☐ Constipation F
- ☐ Diarrhea F
- ☐ Gall bladder problems F
- ☐ Gas F
- ☐ Hemorrhoids F
- ☐ Indigestion/ Heartburn F
- ☐ Vomiting F
- ☐ Vomiting blood F

SKIN
- ☐ Change in moles F
- ☐ Itching F
- ☐ Jaundice F
- ☐ Rashes/ Hives F
- ☐ Sores – not healing F

HEART,LUNG,VASCULAR
- ☐ Blood pressure – low F
- ☐ Blood pressure – high F
- ☐ Cold hands/ feet F
- ☐ Chest pain F
- ☐ Cough – persistent F
- ☐ Heart beat – irregular F
- ☐ Heart beat – rapid F
- ☐ Leg pain – when walking F
- ☐ Shortness of breath F
- ☐ Swelling of ankles F
- ☐ Varicose veins/ Phlebitis F

EAR,EYE,NOSE,THROAT
- ☐ Bleeding gums F
- ☐ Dental problems F
- ☐ Earache R/ L F
- ☐ Ear discharge R/ L F
- ☐ Ear – ringing R/ L F
- ☐ Eye – pain F
- ☐ Hearing loss R/ L F
- ☐ Hoarseness – prolonged F
- ☐ Nosebleeds – recurrent F
- ☐ Sinus problems F
- ☐ Swallowing problems F
- ☐ Vision-blurry/ double F
- ☐ Vision- flashes/ halos F

MEN only
- ☐ Breast lump F
- ☐ Erection difficulty F
- ☐ Testicular lump F
- ☐ Penis discharge F
- ☐ Sore on penis F

WOMEN only
- ☐ Abnormal pap test F
- ☐ Irregular bleeding F
- ☐ Breast lump F
- ☐ High menstrual pain F
- ☐ Hot flashes F
- ☐ Nipple discharge F
- ☐ Painful intercourse F
- ☐ Vaginal discharge F

GENITO-URINARY
- ☐ Blood in urine F
- ☐ Frequent urination F
- ☐ Kidney stones F
- ☐ Less bladder control F

Other _____
_____
_____

HEALTH HISTORY

*Mark conditions you **have Now** (sometime in the last 18 months) and/or **had Before** (not in the last 18 months – **note the age you were**).*

- ADD/ ADHD ☐ Now ☐ Before
- AIDS/ HIV ☐ Now ☐ Before
- Abortion ☐ Now ☐ Before
- Alcoholism ☐ Now ☐ Before
- Allergy Shots ☐ Now ☐ Before
- Anemia ☐ Now ☐ Before
- Aneurysm _____ ☐ Now ☐ Before
- Anorexia ☐ Now ☐ Before
- Anxiety ☐ Now ☐ Before
- Appendicitis ☐ Now ☐ Before
- Arthritis – RA – OA ☐ Now ☐ Before
- Asthma/ Wheezing ☐ Now ☐ Before
- Birth Control Rx _____ ☐ Now ☐ Before
- Bleeding/Blood Disorder ☐ Now ☐ Before
- Breast Lump ☐ Now ☐ Before
- Bronchitis ☐ Now ☐ Before
- Bulimia ☐ Now ☐ Before
- Cancer _____ ☐ Now ☐ Before
- Chemical Dependency ☐ Now ☐ Before
- Chicken Pox ☐ Now ☐ Before
- Colitis/ Crohn's ☐ Now ☐ Before
- Depression ☐ Now ☐ Before
- Diabetes ☐ Now ☐ Before
- Diverticulosis ☐ Now ☐ Before
- Emphysema ☐ Now ☐ Before
- Epilepsy ☐ Now ☐ Before
- Fibromyalgia/ CFS ☐ Now ☐ Before
- Glaucoma / Cataracts ☐ Now ☐ Before
- Goiter ☐ Now ☐ Before
- Gonorrhea ☐ Now ☐ Before
- Gout ☐ Now ☐ Before
- Heart Disease ☐ Now ☐ Before
- Hepatitis ☐ Now ☐ Before
- Hernia ☐ Now ☐ Before
- Herniated Spinal Disc ☐ Now ☐ Before
- Herpes ☐ Now ☐ Before
- High Cholesterol ☐ Now ☐ Before
- Irritable Bowel Disease ☐ Now ☐ Before
- Kidney Disease ☐ Now ☐ Before
- Kidney/ Gall Stones ☐ Now ☐ Before
- Liver Disease ☐ Now ☐ Before
- Low Immune System ☐ Now ☐ Before
- Measles ☐ Now ☐ Before
- Migraine Headaches ☐ Now ☐ Before
- Miscarriage ☐ Now ☐ Before
- Mononucleosis ☐ Now ☐ Before
- Multiple Sclerosis ☐ Now ☐ Before
- Mumps ☐ Now ☐ Before
- Osteoporosis ☐ Now ☐ Before
- Parkinson's Disease ☐ Now ☐ Before
- Pinched Nerve ☐ Now ☐ Before
- Pneumonia/ Pleurisy ☐ Now ☐ Before
- Polio ☐ Now ☐ Before
- Prostate Problem ☐ Now ☐ Before
- Psoriasis/ Eczema ☐ Now ☐ Before
- Psychiatric Care ☐ Now ☐ Before
- Rheumatic Fever ☐ Now ☐ Before
- Scarlet Fever ☐ Now ☐ Before
- Corticosteroid Use ☐ Now ☐ Before
- Stroke (date) _____ ☐ Now ☐ Before
- Suicide thoughts/attempt ☐ Now ☐ Before
- Thyroid problems ☐ Now ☐ Before
- Tonsillitis ☐ Now ☐ Before
- Tuberculosis ☐ Now ☐ Before
- Tumors/Growths ☐ Now ☐ Before
- Ulcers – peptic ☐ Now ☐ Before
- Vaginal Infections ☐ Now ☐ Before
- Whooping Cough ☐ Now ☐ Before
- Other _____

Patient/Guardian Signature: _____ **Date:** _____