PERSONAL MEDICAL HISTORY

DATE _____

NAME _____

BIRTHDATE _____

PLACE _____

NATIONALITY _____

MARITAL STATUS: S M D W

PAST PERSONAL HISTORY — CIRCLE 'YES' OR 'NO'

HAVE YOU EVER HAD			YEAR
Cancer	Yes	No	
Diphtheria	Yes	No	
Hives	Yes	No	
HIV/AIDS	Yes	No	
Malaria	Yes	No	
Measles	Yes	No	
Meningitis	Yes	No	
Mumps	Yes	No	
Polio	Yes	No	
Scarlet fever	Yes	No	
Exposure to TB	Yes	No	
Venereal disease	Yes	No	
Varicose veins	Yes	No	
Kidney Disease	Yes	No	
Arthritis	Yes	No	
Back Pain	Yes	No	
Bronchitis	Yes	No	
COPD	Yes	No	
Emphysema	Yes	No	
Pleurisy	Yes	No	
Pneumonia	Yes	No	
Asthma	Yes	No	
Bladder infection	Yes	No	
Blood transfusion	Yes	No	
Excessive bleeding	Yes	No	
Ulcers	Yes	No	
Glaucoma	Yes	No	
Hay fever/Sinusitis	Yes	No	
Hemorrhoids	Yes	No	
Hepatitis A, B, or C	Yes	No	
Liver Cirrhosis	Yes	No	
Diabetes	Yes	No	
CAD	Yes	No	
High Blood Pressure	Yes	No	
High Cholesterol	Yes	No	
CHF	Yes	No	
PVD	Yes	No	

OPERATIONS			YEAR
Amputation	Yes	No	
Appendix	Yes	No	
Breast	Yes	No	
Gall bladder	Yes	No	
Heart	Yes	No	
Hemorrhoids	Yes	No	
Hernia	Yes	No	
Prostate	Yes	No	
Stomach	Yes	No	
Thyroid	Yes	No	
Tonsils	Yes	No	
Uterus	Yes	No	
Other	Yes	No	
_____			

ALLERGIES		
Penicillin	Yes	No
Sulfa	Yes	No
Tetanus antitoxin	Yes	No
Other drugs	Yes	No
Pollen/Seasonal	Yes	No
Cosmetics	Yes	No
Foods	Yes	No

IMMUNIZATIONS		
Hepatitis	Yes	No
Diphtheria	Yes	No
Varicella (Chicken Pox)	Yes	No
Influenza	Yes	No
M. M. R.	Yes	No
Polio	Yes	No
Smallpox	Yes	No
Tetanus	Yes	No

INJURIES		
Head	Yes	No
Neck	Yes	No
Chest	Yes	No
Back	Yes	No
Abdomen	Yes	No
Broken Bones	Yes	No
Other	Yes	No

EDENVALLEY
INSTITUTE OF WELLNESS

FAMILY HISTORY

HAS ANY BLOOD RELATIVE HAD ANY OF THE FOLLOWING? CIRCLE 'YES' OR 'NO.' IF YES, INDICATE WHAT RELATIONSHIP.

Addictions	Yes	No	_____
Allergies	Yes	No	_____
Anemia	Yes	No	_____
Arthritis	Yes	No	_____
Bleeding	Yes	No	_____
Cancer	Yes	No	_____
Chronic lung disease	Yes	No	_____
Asthma	Yes	No	_____
Convulsions	Yes	No	_____
Diabetes	Yes	No	_____
Frequent diarrhea	Yes	No	_____
Gout	Yes	No	_____
Headaches	Yes	No	_____
Heart disease	Yes	No	_____
Kidney disease	Yes	No	_____
Mental illness	Yes	No	_____
Obesity	Yes	No	_____
Repeated infections	Yes	No	_____
Stroke	Yes	No	_____
Thyroid dysfunction	Yes	No	_____
Tuberculosis	Yes	No	_____
Ulcer	Yes	No	_____
Alcoholism	Yes	No	_____

Relation	Alive? (y/n)	Age/Age at Death	Health (G,F,P)/Cause of Death
Father			
Mother			
Siblings			
1			
2			
3			
4			
Children			
1			
2			
3			

Medications & Supplements Taken	Dosage (in mg)	Times per day

PLEASE FILL NEXT PAGE →

REVIEW OF SYSTEMS CIRCLE 'YES' OR 'NO', IF IN DOUBT, LEAVE BLANK

GENERAL
Night Sweats.....Yes.....No
Persistent Fever.....Yes.....No
Sensitivity to Cold.....Yes..... No
Sensitivity to Heat.....Yes.....No
Tire easily, Fatigue.....Yes.....No
Weight Change.....Yes.....No

SKIN
Change in color.....Yes.....No
Change in hair.....Yes.....No
Change in nails..... Yes.....No
Eruptions (rash) Itchiness..... Yes.....No
Excessive/No sweat.....Yes.....No
Sores..... Yes.....No

EYES
Double vision.....Yes.....No
Eye pain .....Yes.....No
Glasses or contacts.....Yes.....No
Glaucoma.....Yes.....No
Inflamed eyes..... Yes.....No

EARS
Discharge.....Yes.....No
Loss of hearing.....Yes.....No
Ringing in ears.....Yes.....No

NOSE
Excess discharge/Frequent colds.....Yes..... ..No
Loss of smell.....Yes.....No
Nosebleeds.....Yes..... ..No
Obstruction.....Yes.....No

MOUTH
Dental problems.....Yes.....No
Dryness.....Yes.....No
Sore gums.....Yes.....No
Soreness of tongue..... .....Yes.....No

THROAT
Hoarseness.....Yes.....No
Postnasal drainage.....Yes.....No

CARDIO-RESPIRATORY SYSTEM
Bluish fingers or tips.....Yes.....No
Chest pain/discomfort.....Yes.....No
Difficulty in breathing when lying down.....Yes.....No
High blood pressure.....Yes.....No
Pain with breathing.....Yes.....No
Palpitations.....Yes.....No
Shortness of breath/Wheezing.....Yes.....No
Sputum (Phlegm) Cough.....Yes.....No
Swelling in ankles.....Yes.....No
Vein trouble (varicose).....Yes.....No

DIGESTIVE SYSTEM
Abdominal pain.....Yes.....No
Bloody/tarry stools.....Yes.....No
Constipation/Diarrhea.....Yes.....No
Gas/bloating.....Yes.....No
Reflux/heartburn.....Yes.....No

GENITAL-URINAL SYSTEM
Blood in urine/dark urine.....Yes.....No
Feel need to urinate-without much urine.....Yes.....No
Increase in frequency of urination .....Yes.....No (day/night)
Pain/burning on urination.....Yes.....No
Pain with intercourse/lack of sex drive.....Yes.....No
Unable to hold urine.....Yes.....No

MEN
Genital ulcers.....Yes.....No
Impotence.....Yes.....No
Penile discharge.....Yes.....No
Testicular pain/swelling/mass.....Yes.....No

WOMEN
Sensation of foreign body.....Yes.....No
Vaginal discharge.....Yes.....No
Vaginal discomfort.....Yes.....No
Vaginal Ulcers.....Yes.....No

ENDOCRINE
Adrenal dysfunction.....Yes.....No
Diabetes.....Yes..... No
Steroid treatment.....Yes.....No
Thyroid dysfunction.....Yes.....No
Inflamed eyes.....Yes.....No

SKELETAL-MUSCULAR
Joint deformity.....Yes.....No
Muscle camps/weakness.....Yes..... No
Pain/stiffness/swelling in joints.....Yes.....No
Swollen joints.....Yes.....No

NERVOUS SYSTEM
Change in Sensation.....Yes.....No
Convulsion/fits.....Yes.....No
Depression/anxiety.....Yes.....No
Dizziness/fainting.....Yes.....No
Headaches..... Yes.....No
Memory loss.....Yes.....No
Poor coordination.....Yes.....No
Sleeplessness.....Yes.....No
Weakness / paralysis.....Yes.....No

WOMEN

STARTED MENSTRUATING AT AGE: _____
INTERVAL BETWEEN PERIODS: _____
PAIN: YES NO DURATION OF BLEEDING: _____
FLOW: LIGHT NORMAL HEAVY
DATE OF LAST PERIOD:_____
NUMBER OF PREGNANCIES: _____
NUMBER OF MISCARRIAGES: _____
NUMBER OF BIRTHS: _____
WEIGHT OF BABY(IES) AT BIRTH: _____
DATE OF LAST PAP: _____

OTHER HABITS

BREAKFAST: _____
LUNCH: _____
SUPPER: _____
HOW MUCH WATER DO YOU DRINK?_____
DO YOU GET SUNSHINE DAILY? YES NO
DO YOU GET PLENTY OF FRESH AIR DAILY? YES NO
AVERAGE HOURS OF SLEEP EACH NIGHT_____
RECREATION _____
EXERCISE _____
ALCOHOL _____(daily/weekly)
TOBACCO _____(daily/weekly)