Patient Medical History Patient Name_____ Date_____

General Health

N/A	Past	Present	
❍	❍	❍	Insomnia
❍	❍	❍	Chills
❍	❍	❍	Dizziness/Faintness
❍	❍	❍	Fever
❍	❍	❍	Weight Loss
❍	❍	❍	Numbness
❍	❍	❍	Sweats
❍	❍	❍	Joint Pain/Weakness
❍	❍	❍	Bone Pain
❍	❍	❍	Joint Pain
❍	❍	❍	Blood in Urine
❍	❍	❍	Frequent Urination
❍	❍	❍	Painful Urination
❍	❍	❍	Shortness of Breath
❍	❍	❍	Cough
❍	❍	❍	Other _____

Gastrointestinal

❍	❍	❍	Poor Appetite
❍	❍	❍	Bloating
❍	❍	❍	Constipation/Diarrhea
❍	❍	❍	Change in Bowels
❍	❍	❍	Excessive Thirst
❍	❍	❍	Flatulence/Gas
❍	❍	❍	Hemorrhoids
❍	❍	❍	Indigestion
❍	❍	❍	Nausea
❍	❍	❍	Rectal Bleeding
❍	❍	❍	Stomach Pain
❍	❍	❍	Vomiting
❍	❍	❍	Blood in Vomit
❍	❍	❍	Eating Disorder
❍	❍	❍	Other_____

Cardiovascular

❍	❍	❍	Chest Pain
❍	❍	❍	Low Blood Pressure
❍	❍	❍	High Blood Pressure
❍	❍	❍	Irregular Heart Beat
❍	❍	❍	Poor Circulation
❍	❍	❍	Swelling in Ankles
❍	❍	❍	Varicose Veins
❍	❍	❍	Neuropathy
❍	❍	❍	Other_____

Eye Ear Nose Throat

N/A	Past	Present	
❍	❍	❍	Bleeding Gums
❍	❍	❍	Blurred/Double Vision
❍	❍	❍	Difficulty Swallowing
❍	❍	❍	Earache
❍	❍	❍	Loss of Hearing
❍	❍	❍	Nosebleeds
❍	❍	❍	Persistent Cough
❍	❍	❍	Ringing in Ears
❍	❍	❍	Sinus Problems/Infections
❍	❍	❍	Halos/Flashes in Vision
❍	❍	❍	Macular Degeneration
❍	❍	❍	Glaucoma

Skin

❍	❍	❍	Shingles
❍	❍	❍	Bruise Easily
❍	❍	❍	Hives
❍	❍	❍	Itching/Rashes
❍	❍	❍	Sores that won't heal
❍	❍	❍	Dry Skin
❍	❍	❍	Other_____

Infectious Disease

❍	❍	❍	HIV/AIDS
❍	❍	❍	Chicken Pox
❍	❍	❍	Hepatitis
❍	❍	❍	Herpes
❍	❍	❍	Measles
❍	❍	❍	Mumps
❍	❍	❍	Pneumonia
❍	❍	❍	Polio
❍	❍	❍	Rheumatic Fever
❍	❍	❍	Scarlet Fever
❍	❍	❍	Tuberculosis
❍	❍	❍	STDs
❍	❍	❍	Meningitis
❍	❍	❍	Other_____

Men Only

❍	❍	❍	Erectile Dysfunction
❍	❍	❍	Abnormal Prostate
❍	❍	❍	Low Levels of Testosterone
❍	❍	❍	Testicular Abnormalities
❍	❍	❍	Erectile Dysfunction
❍	❍	❍	Other_____

Women Only

N/A	Past	Present	
❍	❍	❍	Abnormal Pap Smear
❍	❍	❍	Abnormal Bleeding
❍	❍	❍	Lump in Breast
❍	❍	❍	Menstrual Cramps
❍	❍	❍	Hot Flashes
❍	❍	❍	Currently Pregnant
❍	❍	❍	# of pregnancies ____
❍	❍	❍	PMS
❍	❍	❍	Menopause
❍	❍	❍	Female Orgasmic Disorder
❍	❍	❍	Other_____

Environmental

❍	❍	❍	Exposure to Toxins
❍	❍	❍	Exposure to Radiation

Disease/Infection

❍	❍	❍	Parkinson's Disease
❍	❍	❍	Fibromyalgia
❍	❍	❍	Appendicitis
❍	❍	❍	Arthritis
❍	❍	❍	Asthma
❍	❍	❍	Bleeding Disorders
❍	❍	❍	Cancer
❍	❍	❍	Chemical Dependency
❍	❍	❍	Tic Disorder
❍	❍	❍	Diabetes
❍	❍	❍	Epilepsy
❍	❍	❍	Heart Disease
❍	❍	❍	High Cholesterol
❍	❍	❍	Kidney Disease
❍	❍	❍	Liver Disease
❍	❍	❍	Migraines
❍	❍	❍	Multiple Sclerosis
❍	❍	❍	Stroke
❍	❍	❍	Thyroid Problems
❍	❍	❍	Ulcers
❍	❍	❍	Cerebral Palsy
❍	❍	❍	Seizure Disorder
❍	❍	❍	Other_____

Health Habits

N/A	Past	Present	
❍	❍	❍	Caffeine Type_____
❍	❍	❍	Amount_____
❍	❍	❍	Tobacco Type_____
❍	❍	❍	Amount_____
❍	❍	❍	Abuse of Prescription Drugs
❍	❍	❍	Nicotine Type_____
❍	❍	❍	Alcohol Amount_____
❍	❍	❍	Inhalants
❍	❍	❍	Other_____

List the medication you are currently taking to include dosage

_____

_____

_____

List ALL allergies to environment, medication, animal, food, and substance

_____

_____

List medications you have taken in the past and if they worked for you or not

_____

_____

_____

Date of Last Physical _____

Physician(s)_____

Current Medical Concerns

_____

_____

_____

List all Surgeries, Accidents, or Trauma to include approximate date

_____

_____

_____

_____

Past medical conditions to include treating physician and outcomes

_____

_____

_____

List ALL occasions when you experienced a concussion or traumatic brain injury

_____

_____

Who was the treating physician?_____

What was the outcome of the concussion or brain injury? Did you experience any behavior or mood changes?

_____

_____

List any occasion where you experienced trauma to the neck or back

_____

_____

Other health concerns or issues _____

_____

_____

Biological Family Medical History

Father **Living or Deceased** If deceased, state cause and age _____
Present Health Problems _____
Hospitalizations _____

Mother **Living or Deceased** If deceased, state cause and age _____
Present Health Problems _____
Hospitalizations _____

Maternal Grandfather **Living or Deceased** If deceased, state cause and age _____
Present Health Problems _____
Hospitalizations _____

Maternal Grandmother **Living or Deceased** If deceased, state cause and age _____
Present Health Problems _____
Hospitalizations _____

Paternal Grandfather **Living or Deceased** If deceased, state cause and age _____
Present Health Problems _____
Hospitalizations _____

Paternal Grandmother **Living or Deceased** If deceased, state cause and age _____
Present Health Problems _____
Hospitalizations _____

Siblings with Health Concerns _____
Diagnosis_____
Current Status _____

Please note here any other biological relatives with significant health concerns/problems
_____
_____
_____

Please understand: If it is reported to any PAS clinical or support staff that you have an infectious disease that your physician or care provider(s) does not know about, PAS is required by law to report it to our Local Health Department. Also, if it is reported that you have an infectious disease and are participating in activities that may unknowingly infect another person or persons, PAS is also required by law to report to local health department and law enforcement.

If you have a contagious illness/disease, please let us know so that we may provide a safe place for you to wait outside of the general waiting room area as not to infect other individuals.

THIS FORM IS PART OF THE COMPREHENSIVE DIAGNOSTIC ASSESSMENT USED TO GLEAN PERTINENT MEDICAL INFORMATION.