DESERT MOUNTAIN HEALTH CENTER

HISTORY FORM A

Patient name: ____ Chart no. ______________

Date: _______________

Please list any medication you take (prescription or over-the-counter): __________________________________

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Please list any surgeries or hospitalizations you have ever undergone: __________________________________

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Answers to the questions below will aid in your care. Please indicate in front of ALL of the following signs and symptoms, 1(Never); 2 (Previously); or 3 (Presently). Details can be added on page 2.

1.GENERAL SYMPTOMS

a____ Headaches
b____ Fever
c____ Chills
d____ Night sweats
e____ Fainting
f____ Dizziness
g____ Convulsions
h____ Loss of sleep
i____ Fatigue
j____ Nervousness
k____ Loss of weight
l____ Numbness or pain in arms,legs or hands
m____ Allergy ___________
n____ Wheezing
o____ Neuralgia
p____ Chronic fatigue syn.
q____ Fibromyalgia
r____ Diabetes

2.MUSCLES & JOINTS

a____ Weakness
b____ Twitching
c____ Stiff neck
d____ Backache
e____ Swollen joints
f____ Tremors
g____ Foot trouble
h____ Painful joints
i____ Pain between shoulders
j____ Hernia
k____ Spinal curvature
l____ Sore muscles

3.GASTRO-INTESTINAL

a____ Poor appetite
b____ Poor digestion
c____ Excessive hunger
d____ Belching or gas
e____ Nausea
f____ Vomiting
g____ Vomiting blood
h____ Pain over stomach
i____ Constipation
j____ Diarrhea
k____ Colon trouble
l____ Hemorrhoids
m____ Liver trouble
n____ Jaundice
o____ Gall bladder trouble
p____ Food cravings
q____ Itching roof of mouth

4.CARDIOVASCULAR

a____ Rapid heart rate
b____ Slow heart rate
c____ High blood pressure
d____ Low blood pressure
e____ Pain over heart
f____ Previous heart trouble
g____ Swelling of ankles
h____ Poor circulation
i____ Varicose veins
j____ Stroke

5.EYE/EAR/NOSE/THROAT

a____ Poor vision
b____ Crossed eyes
c____ Pain in eyes
d____ Deafness
e____ Earache
f____ Ear noises
g____ Ear discharge
h____ Nasal obstruction
i____ Nose bleeds
j____ Sore throat
k____ Hoarseness
l____ Hay fever
m____ Frequent colds
n____ Enlarged thyroid
o____ Tonsilitis
p____ Sinus trouble

6.SKIN OR ALLERGIES

a____ Skin eruptions
b____ Itching
c____ Bruise easily
d____ Dryness
e____ Boils
f____ Sensitive skin
g____ Hives
h____ Eczema
i_____ Reaction to medication

7.RESPIRATORY

a____ Chronic cough
b____ Spitting blood
c____ Spitting phlegm
d____ Chest pain
e____ Difficulty breathing
f____ Asthma

8.GENITO-URINARY

a____ Frequent urination
b____ Painful urination
c____ Blood in urine
d____ Kidney infection
e____ Bedwetting
f____ Inability to hold urine
g____ Prostate trouble

9.FOR WOMEN ONLY

a____ Painful periods
b____ Excessive flow
c____ Irregular cycles
d____ Hot flashes
e____ Cramps or backache
f____ Miscarriage
g____ Vaginal discharge
h____ Fibroids
i_____ Ovarian cyst
j______PMS
k____ No. of pregnancies
l____ No. of children
m. Last pap smear

____
(date)

HISTORY FORM, Page 2

NAME: ___________________

10. HAVE YOU EVER HAD:

a____ Appendicitis
b____ Pneumonia
c____ Thyroid problem
d____ Rheumatic fever
e____ Polio
f____ Tuberculosis
g____ Anemia
h____ Measles
i____ Mumps
j____ Chicken pox
k____ Diabetes
l____ Cancer
m____ Heart disease
n____ Goiter
o____ Influenza
p____ Depression
q____ Alcoholism
r____ Veneral infection
s____ Arthritis
t____ Epilepsy
u____ Candida infection
v____ Mononucleosis

11. FAMILY HISTORY

	Diabetes	*Heart*	*Kidney*	*Cancer*	*Back*
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother – no.	☐	☐	☐	☐	☐
Sister – no.	☐	☐	☐	☐	☐

12. HABITS

a____ Smoking___pks/day_____ no. years
b____ Drinking___________
c____ Coffee___cups/day

13. EXERCISE

a_____ None
d_____ Daily
b_____ Occasional
c_____ 2-3 times/week

FEEL FREE TO ELABORATE ON ANY ITEM YOU HAVE CHECKED. REFERENCE THE COMMENT WITH THE NUMBER AND LETTER OF THE ITEM ON THE QUESTIONNAIRE.

(For example, if you want to describe hoarseness which you have experienced, write "5k" before your comment.)

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