YO SAN UNIVERSITY CLINIC
PATIENT MEDICAL HISTORY

Please fill in ALL PAGES BEFORE YOUR APPOINTMENT. Your answers will help us plan and provide your care. Leave blank any parts you are unsure of, or do not wish to answer. Any information provided will be kept confidential.

CURRENT MEDICAL HISTORY

Do you have allergies? □ Yes □ No □ Not Sure / Don't know

If so, please list: _____

Do you wear a cardiac pacemaker? □ Yes □ No □ Not Sure / Don't know

Family Medical History: Does any member of your family (parents & siblings) have any of the following?

Diabetes Hypertension Cardiovascular diseases Autoimmune diseases
Cancer Stroke Seizures

If so, please describe: _____

_____

Occupation: _____

Do you have a regular exercise program? □ Yes □ No
If so, please describe: _____

Do you have any dietary restrictions? □ Yes □ No
If so, please describe: _____

Please describe your average daily diet:
Morning Afternoon Evening

_____

_____

_____

Do you smoke? □ Yes □ No, never smoked □ No, I have quit smoking
If yes, how many packs of cigarettes do you smoke a day? _____

How much coffee, tea, or caffeinated beverage do you consume?
□ 1-2 cups per day □ 2-5 cups per day □ >5 cups per day □ occasional/social □ None

How much alcohol do you consume per week?
□ 1-2 glasses per day □ 2-5 glasses per day □ >5 glasses per day □ occasional/social □ None

Please describe any use of drugs for non-medical purposes: _____

Patient Name: _____ Date: _____

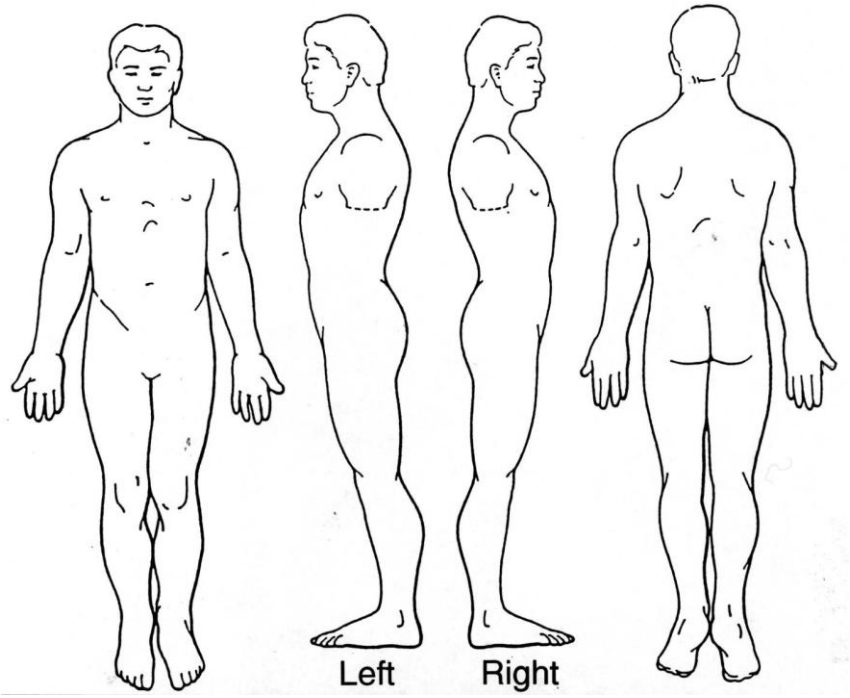
PAIN:

Do you have pain? □ Yes □ No

If so, please describe: _____

_____

Please indicate affected and/or painful area(s)



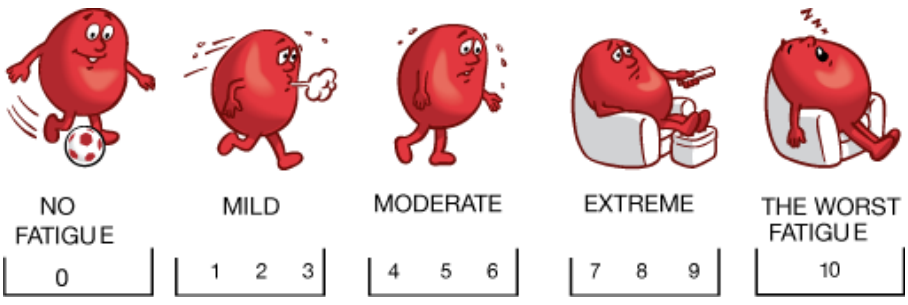
Pain	
x	Little
xx	Moderate
xxx	strong

FATIGUE:

Do you feel fatigued? □ Yes □ No

If so, please describe: _____

_____



Patient Name: _____ Date: _____

Women only:

Are you pregnant now? □ Yes □ No

Number of pregnancies:_____ Number of children:_____

Age of first period:_____ Age of menopause:_____

Is your menstrual cycle regular? □ Yes □ No □ Post-menopausal

1. Average number of days in flow:_____
2. Volume: □ Normal □ Heavy □ Light
3. Color: □ Normal □ Dark red □ Purple □ Light brown
4. Do you have the following menstruation related signs/symptoms?

□ Blood clots □ Cramps □ Nausea □ Breast distension

□ Mood changes □ Bleeding/spotting between periods

□ Heavy vaginal discharge between periods

Do you use any contraception? □ Yes □ No □ Not applicable

If Yes, please describe:_____

Libido (sex drive) is:

□ Low □ Normal □ High

Men Only

Do you experience any of the following? (*please check all that applies)*

□ Feeling coldness or numbness in the external genitalia □ Pain or swelling in testicles

□ Premature ejaculation □ Impotence/ erectile dysfunction

Libido (sex drive) is:

□ Low □ Normal □ High

MEDICATIONS

Please list all the medications you are currently taking, including all vitamins and supplements

Name of medication	Dose	Frequency

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS *Put a check mark by the symptom(s) that you are currently experiencing:*

Constitutional Symptoms
___ Fatigue / low energy
___ Poor appetite
___ Insomnia / poor sleep
___ Fever or chills
___ Night sweats
___ Heat sensation or hot flashes
___ Unexplained weight loss or weight gain
Other: _____

Allergy / Immunological
___ Hay Fever
___ Other: _____

Ear / Nose / Throat / Oral
___ Ear Infection
___ Hearing loss
___ Sinus problems
___ Sore throat
___ Oral (canker) sores
___ Bleeding, swollen painful gums
___ Halithosis (bad breath)
Other: _____

Eyes / Vision
___ Blurred / double vision
___ Eye pain
___Dryness / irritation
Other: _____

Gastrointestinal
___ Heart burn
___ Nausea / vomiting
___ Abdominal pain / cramps
___ Diarrhea
___ Constipation
___ Palpitations
___ Bleeding from rectum
___ Black sticky stools
___ Hemorrhoids
___ Change in bowel habits
Other: _____

Respiratory
___ Chronic cough
___ Chest congestion
___ Difficulty breathing / shortness of breath
___ Recurrent chest infection
___ Asthma / wheezing
Other: _____

Cardiovascular
___ Chest pain
___ High blood pressure
___ Palpitations
___ Edema / swelling
Other: _____

Neurological
___ Headaches
___ Dizziness / fainting
___ Numbness / tingling
___ Tremors
___ Seizures / epilepsy
Other: _____

Musculoskeletal
___ Joint pain / stiffness / swelling
___ Neck pain / stiffness
___ Back pain / stiffness
___ Muscle weakness
Other: _____

Endocrine
___ Excessive thirst
___ Feeling too hot / too cold
___ Diabetes
Other: _____

Urinary
___ Blood in urine
___ Bladder / kidney infection
___ Problem with urination
___ Bladder / kidney stones
Other: _____

Hematological / Lymphatic
___ Easy bruising
___ Swollen glands
___ Excessive bleeding
___ Blood clotting problems
Other: _____

Skin / Dermatological
___ Skin rash
___ Persistent itch
Other: _____

Gynecological
___ Abnormal / irregular bleeding
___ Abnormal vaginal discharge
___ Hot flashes
___ Breast lump, pain or discharge
___ Hot flashes
Other: _____

Psychological
___ Feeling sad or depressed
___ Worried / anxious
Other: _____

Patient Name: _____ Date: _____