

1 World Medicin Inc.

Uniting Western, Eastern, and Holistic Medicines
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HISTORY OF PAST ILLNESS: Have you had

Childhood:

- Measles Mumps Chicken Pox
 Congenital Abnormalities Rheumatic fever or heart disease

Adult:

- Asthma High Blood Pressure Depression
 Diabetes Ulcer or Gastritis Thyroid Problems
 Tuberculosis Kidney Problems Liver Problems
 Blood Problems Sexually Transmitted Disease Heart Failure
 Abnormal Heart Rhythms Circulation Problems
 Anxiety Cancer (Site _____)

Have you had any serious illness? Yes No

Have you ever had a transfusion Yes No

Have you ever been hospitalized or been

under medical care for more than 6 months Yes No

If Yes, for what reason? _____

Most recent immunizations:

Hepatitis B _____ (date) Flu Vaccine _____ (date)
 (date) Pneumovax _____ (date) Tetanus _____ (date)

OPERATIONS:

Have you ever had any surgery? Yes No

- List: Appendectomy Gallbladder
 Ovaries Removed Joint Replacement
 Bypass (if so, what _____)
 Hysterectomy (if so, reason _____)
 Other _____

ALLERGIES:

MEDICATIONS:

INJURIES:

Have you ever been seriously injured in a motor vehicle accident? Yes No
 Have you ever been knocked unconscious? Yes No

Circle One:

Single Married Separated
 Divorced Widowed Significant Other

With whom do you live? _____

Recreational Drug Usage? Yes No

Do have any problems with sexual function? Yes No

Foreign travel within the last year? Yes No

Coffee _____ Tea _____ Cola's _____ (per day)

Alcoholic Beverages: Never _____ less than 1 per week _____

1-5 per week _____ Other _____ Tobacco:

Tobacco Never Smoked Quit _____ years ago

Years smoked _____ packs per day _____

SOCIAL HISTORY: (Continued)

Are you employed? Yes No Full time/Part time (Circle)

What is your job? _____

How much time have you lost from work because of your health during the past?

Six Months _____ One year _____ Five years _____

Are you exposed to fumes, dust or solvents? _____

Education: (years)

Grade School _____ High School _____ College _____

Do you wear seatbelts? Always Sometimes Never

FAMILY HISTORY	Age	Health	If Deceased Age at Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother, child or grandparent ever had?

Stroke	Yes	No	Heart Trouble	Yes	No
Tuberculosis	Yes	No	High Blood Pressure	Yes	No
Diabetes	Yes	No			
Cancer	Yes	No	Bleeding Tendency	Yes	No
TYPE					
Suicide	Yes	No	Gout or other Crippling Arthritis	Yes	No
Mental Illness	Yes	No	Hereditary Defects	Yes	No

AMBULATORY CARE MEDICAL HISTORY FORM

Page -2- CIRCLE YES OR NO FOR THOSE THAT APPLY WITHIN THE LAST TWO WEEK PERIOD

SYSTEMIC REVIEW:

General: Maximum weight _____ Minimum weight _____

Recent Changes Yes No

Have you been in good general health most of your life? Yes No

Have you recently had?

Weakness Fever Chills

Night Sweats Fainting Problems Sleeping

Do you have any of the following:?

Skin:

Skin disease Yes No

Have you ever had a transfusion Jaundice Yes No

Hives, eczema or rash Yes No

Head-Eyes-Ears-Nose-Throat

Dry eyes or mouth Yes No

Bleeding Gums - Frequent or Constant Yes No

Blurred Vision Yes No

Date of Last Eye Exam _____

Sneezing or runny nose Yes No

Nosebleeds - Frequent Yes No

Chronic sinus trouble Yes No

Ear disease Yes No

Impaired hearing Yes No

Dizziness or sensation of room spinning Yes No

Frequent or severe headaches Yes No

Respiratory:

Asthma or Wheezing Yes No

Difficulty breathing Yes No

Any trouble with lungs Yes No

Pleurisy or Pneumonia Yes No

Cough up Blood Yes No

Persistent cough for 3-6 months Yes No

Cardiovascular:

Chest pain, pressure or tightness Yes No

Shortness of breath with walking or lying down Yes No

Difficulty walking two blocks Yes No

Palpations Yes No

Swelling of hands, feet or ankles Yes No

Needs to sleep with 2 or more pillows Yes No

Heart Murmur Yes No

Gastrointestinal:

Vomiting blood or food Yes No

Gallbladder disease Yes No

Change in appetite Yes No

Hepatitis/Jaundice Yes No

Painful bowel movements Yes No

Bleeding with bowel movements Yes No

Black stools Yes No

Hemorrhoids or piles Yes No

Recent change in bowel habits Yes No

Frequent diarrhea Yes No

Heartburn or indigestion Yes No

Cramping or pain in the abdomen Yes No

Does food stick in throat Yes No

Endocrine:

Hormone therapy Yes No

Any change in hat or glove size Yes No

Any change in hair growth Yes No

Do you feel colder than before or skin feel dryer Yes No

Neck:

Stiffness Yes No

Enlarged glands Yes No

Genitourinary:

Loss of urine Yes No

Blood in urine Yes No

Frequent urination Yes No

Burning or painful on urination Yes No

Night time urinating Yes No

Kidney trouble Yes No

Problem stopping/starting flow of urine Yes No

Testicular mass Yes No

Prostate trouble Yes No

Sexual dysfunction Yes No

STD/AIDS Risk Yes No

Gynecological:

First day of last period _____

Age period started _____

How long do periods last? _____ days

Frequency of periods every _____ days

Pain with periods Yes No

Number of pregnancies _____

Number of miscarriages _____

Date of last cancer smear and results _____

Breast lump Yes No

Abnormal Vaginal Discharge Yes No

Breast Discharge Yes No

Skin change of Breast Yes No

Nipple retraction Yes No

Locomotor-Musculoskeletal:

Stiffness or pain in joints (check all that apply)

Finger Hands Wrist Elbows Shoulders Neck Back

Hip Knee Toes Foot Jaw

Weakness of muscles or joints Yes No

Any difficulty in walking Yes No

Any pain in calves or buttocks on walking Yes No

Is pain relieved by rest Yes No

Neuro-Psychiatric:

Transient blindness Tremor Numbness in fingers Weakness

Have you ever had counseling for your mental health? Yes No

Have you ever been advised to see a psychiatrist? Yes No

Do you ever have, or have had fainting spells? Yes No

Convulsions Yes No

Paralysis Yes No

Problems with coordination Yes No

Domestic violence Yes No

Depression Symptoms (difficulty sleeping, loss of appetite loss of interest in activities, feelings of hopelessness) Yes No

Hematologic:

Are you slow to heal after cuts Yes No

Anemia Yes No

Phlebitis or blood clots in veins Yes No

Have you had difficulty with bleeding excessively after tooth extraction or surgery? Yes No

Have you ever had abnormal bruising or bleeding? Yes No

Source of information, if other than patient: _____ Signature: _____

Provider _____ Signature of Patient _____ Date _____