MPM MIDDLE PATH MEDICINE

MEDICAL HISTORY (1)

 PLEASE COMPLETE ALL 4 PAGES. Today's Date: ________

Name:__________________________ **Age:**______ **Date of Birth:**________ **Sex:** M/F

Marital Status (circle one): single married life partner divorced widowed

Do you have children? If yes, please list names and ages: ____

____

If you need additional space for any of the following questions, ***please*** *attach an extra page.*

PRESENT HEALTH CONCERNS:

What are your most important health concerns listed in order of importance?
Describe in detail the history of these symptoms and the effect they have on your life.

1. ______________________________ 4. ______________________________
2. ______________________________ 5. ______________________________
3. ______________________________ 6. ______________________________

MEDICINES:

Please list all of the **prescription** and **over-the-counter medications** you are currently taking *including dosage and frequency*:

____
____
____

SUPPLEMENTS:

Please list all of the **nutritional** and **herbal supplements** you are taking including *brand name, dosage and frequency*:

____
____
____

ALLERGIES:

Please list all known **allergies** (drug, food, chemical and environmental):

____
____

MEDICAL HISTORY:

Please list all hospitalizations and treatments you have used for various ailments, both conventional and alternative.
Indicate the effectiveness of each treatment. ____

____
____
____

SURGICAL HISTORY:

Please list any **surgeries** and dates: ____

____
____

ACCIDENTS:

Please describe all serious **accidents**, severe injuries, head injuries and broken bones and dates:__________________

____
____

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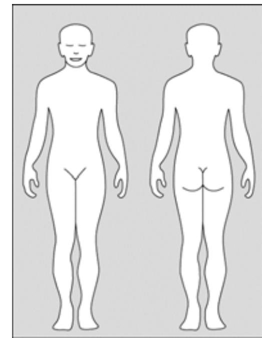
MEDICAL HISTORY (2)



On the picture, mark and "X" on the picture where you continue to have pain, numbness and/or tingling.
Please rate the severity of pain on a scale of 1-10 (1=least pain): ____________
Type of pain: Sharp Dull Throbbing Numbness Aching
Shooting Burning Tingling Cramps Stiffness Swelling Other
How often do you have this pain? ____________
Is it constant or does it come and go? ____________
Activities that are painful: Sitting Standing Walking Bending Lying down

Have you ever had the following (circle "Y" for yes and "N" for no)?

Alcoholism	Y	N	Anemia	Y	N	Anorexia/Bulimia	Y	N
Arthritis	Y	N	Asthma	Y	N	Back Trouble	Y	N
Bleeding/Bruising	Y	N	Blood Transfusion	Y	N	Breast Lump	Y	N
Bronchitis (chronic)	Y	N	Cancer	Y	N	Cataracts	Y	N
Diabetes	Y	N	Drug Dependency	Y	N	Emphysema	Y	N
Epilepsy	Y	N	Glaucoma	Y	N	Gout	Y	N
Heart Disease	Y	N	Hemorrhoids	Y	N	Hernia	Y	N
High Blood Pressure	Y	N	High Cholesterol	Y	N	Hives/Eczema	Y	N
Kidney Disease	Y	N	Liver Disease	Y	N	Low Blood Pressure	Y	N
Migraines	Y	N	Mitral Valve Prolapse	Y	N	Multiple Sclerosis	Y	N
Pacemaker	Y	N	Prostate Problems	Y	N	Psychiatric Care	Y	N
Stroke	Y	N	Thyroid Disease	Y	N	Ulcers	Y	N
Varicose Veins	Y	N	Other ____________					

Have you ever had any of the following infections (please circle any infection you have ever had)?

AIDS/HIV	Bladder Infections	Bronchitis	Chicken Pox	Diptheria
Hepatitis	Herpes	Measles	Mono	Mumps
Pneumonia	Polio	Rheumatic Fever	Rubella	Scarlet Fever
Sexually Transmitted	Shingles	Sinusitis	Tonsillitis	Tuberculosis
Typhoid Fever	Vaginal Infections	Whooping Cough		

FOR WOMEN

Age at 1st period: ____________
Period frequency (i.e. 28 days) ____________
Days of flow? ____________
Any problems with PMS? ____________
Any irregularities with periods? ____________
Last menstrual period? ____________
Extreme menstrual pain? ____________
Are you satisfied with sex life? ____________
Any history of infertility? ____________

Last Pap: ____________
Ever have an abnormal Pap? Yes No
If "yes" describe: ____________
____
Do you do self breast exam? Yes No
Last mammogram? ____________
History of breast lump? Yes No
If "yes", describe: ____________
Any hot flashes or night sweats? Yes No

List each pregnancy including abortions, miscarriages and births (including *birth date*). If complications with pregnancy or delivery (including C-section), please describe: ____________

____

____

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MEDICAL HISTORY (3)

FOR MEN

Last prostate exam? ____________ Last PSA? ____________

How many times do you get up at night to urinate? ____________

Are you satisfied with your erections? Y N Are you satisfied with your sex life? Y N

MEDICAL SERVICES

Please indicate the date you last received the following or put N/A for services that do not apply to you:

Tetanus shot ________ Flu shot ________ Pneumonia shot ________

Blood tests ________ EKG ________ Chest X-Ray ________

Colonoscopy ________ Eye Exam ________ Dental Exam ________

Bone Density ________ Coronary calcium score ________

LIFESTYLE

List other physicians/healers you are seeing (name/phone): ____________

DIET

Do you have any dietary restrictions? ____________

Do you have any cravings for any particular type of food (be specific)? ____________

Are you satisfied with your diet? Yes No

If "no" to the above, why? ____________

How much water do you drink daily? ________ Other liquids? ________

What did you eat and drink yesterday or a typical day (please be specific)?

Breakfast: ____________

Snack: ____________

Lunch: ____________

Snack: ____________

Dinner: ____________

Snack: ____________

Smoking (type and amount per day) ____________

If you are a former smoker, what was your quit date? ____________

Do you drink alcohol? (type and amount per week) ____________

If you used to drink alcohol, when did you quit? ____________

Do you drink caffeine? (type and amount per week) ____________

Do you use recreational drugs? (type and amount per week) ____________

Usual weight? ________ Are you happy with your weight? ________

How much sleep do you get? ________ Do you feel rested enough? ________

EXERCISE:

Please describe the exercise you do each week (include minutes per session and days per week):

____

Do you enjoy exercise? Yes No

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MEDICAL HISTORY (4)

 PLEASE COMPLETE ALL 4 PAGES.

STRESS LEVEL AND STRESS REDUCTION

Describe your stress level (circle one): none mild moderate severe

Describe any stress reduction you practice including minutes per session and frequency: ______

Do you enjoy your work/what you do during the day? ______
Do you enjoy the people/pets in your life? ______
Do you live near an agricultural/industrial area? ______
Do you use paint, chemicals or solvents at home, for hobbies, or during work? ______
Have you moved to a new home recently? ______
Have you done any remodeling recently? ______
Do you have any mold in your home or work area? ______
Do you suffer from allergies? ______
How many times have you used antibiotics in the past two years? ______
List dental history (procedures): ______

List any cosmetic surgery or procedures: ______
List travel history and vaccinations: ______

FAMILY HISTORY

(please include any family member who has had the following illnesses):

			Relationship				Relationship
Allergies/Asthma	N	Y		Anemia	N	Y	
Arthritis	N	Y		Bleeding	N	Y	
Cancer	N	Y		Depression	N	Y	
Diabetes	N	Y		Drugs/Alcohol	N	Y	
Gout	N	Y		Heart Disease	N	Y	
High Blood Press.	N	Y		High Cholesterol	N	Y	
Kidney Disease	N	Y		Mental Illness	N	Y	
Migraines	N	Y		Obesity	N	Y	
Stroke	N	Y		Thyroid Disease	N	Y	

Other: ______

	Present Age	Age at Death	If living, current health (good, fair, poor) If Deceased, Cause of Death
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			
Father			
Mother			
Siblings			
Spouse			
Children			

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