MPM MIDDLE PATH MEDICINE

MEDICAL HISTORY (1)

(PAGE 1 OF 4) 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)

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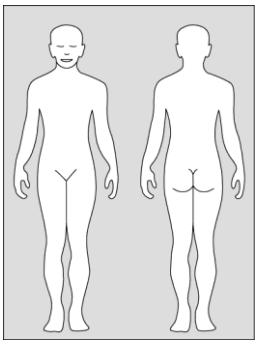

On the picture, mark and "X" on the picture where you continue to have pain, numbness and/or tingling.
Please rate the severity of pain on a scale of 1-10 (1=least pain): _____
Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ 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 had 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)

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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)

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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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