

BOULDER OSTEOPATHIC CENTER
MEDICAL HISTORY

Patient's Name: _____
Date: _____

Please complete entire medical history and write "N/A" in any section that is not applicable.

MEDICATIONS:

List medications you are taking now including vitamins, Aspirin, Tylenol, Advil, etc., the reason for each and the name of doctor who prescribed or recommended it: _____

Allergies to medications: _____

Other allergies: _____

NEUROLOGICAL HISTORY:

Please check if you have had any of these and give age of onset, frequency of incident and details.

- | | |
|--|-------|
| _____ Fainting spells | _____ |
| _____ Dizziness | _____ |
| _____ Equilibrium/Balance | _____ |
| _____ Motion sickness | _____ |
| _____ Tinnitus (ear ringing) | _____ |
| _____ Hearing loss | _____ |
| _____ Vision Problems | _____ |
| _____ Memory Problems | _____ |
| _____ Attention/Concentration problems | _____ |
| _____ Weakness in extremities | _____ |
| _____ Burning in extremities | _____ |
| _____ Numbness in extremities | _____ |
| _____ Cramps in extremities | _____ |
| _____ Difference between sides of body | _____ |
| _____ Other | _____ |

Have you had any diagnostic tests done (e.g. X-ray, EMG, CAT scan, MRI)? If yes, please give the doctor's name, where the test was done, approximate date, and results.

1. _____
2. _____
3. _____
4. _____
5. _____

SURGERIES:

Please list all surgeries with approximate date or your age at the time:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

HEADACHES:

Age at onset: _____ Frequency: _____

Pattern: _____

Duration: _____

Any diagnosis or treatment: _____

ILLNESSES:

Please circle any you have had.

Measles	Rubella (German Measles)	Chicken Pox	Mumps	Whooping Cough	Scarlet Fever
Rheumatic Fever	Tonsillitis/Strep Throat	Ear Infections	Sinusitis	Pneumonia	Bronchitis
Croup	Infectious Mononucleosis	Meningitis	Urinary Tract Infection	Staph Infection	Yeast Infection

Other: _____

OTHER HEALTH CONDITIONS:

Please check if you have had any of these and give the age of onset and frequency of incident or list as "ongoing".

- _____ Anemia _____
- _____ Diabetes _____
- _____ Hypoglycemia _____
- _____ High blood pressure _____
- _____ Low blood pressure _____
- _____ Heart problems _____
- _____ Thyroid problems _____
- _____ Gallbladder problems _____
- _____ Kidney problems _____
- _____ Asthma _____

_____ Other respiratory problems _____
 _____ Cancer _____
 _____ Obesity/Overweight _____
 _____ Under weight _____
 _____ Back problems _____
 _____ Neck problems _____
 _____ Scoliosis _____
 _____ Ulcer/stomach problems _____
 _____ Constipation _____
 _____ Irritable bowel _____
 _____ Hiatus hernia _____
 _____ Other digestive problems _____
 _____ Bladder problems _____
 _____ Rheumatoid arthritis _____
 _____ Foot problems _____
 _____ Hepatitis A B _____
 Other _____

GYNECOLOGICAL HISTORY:

Please circle any of the following you have had.

PMS	Menstrual Cramps	Heavy Bleeding	Infertility	Miscarriages	Hot flashes
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Other: _____

PREGNANCIES:

How many: _____ Complications: _____

SMOKING:

Do you smoke: ___No___Yes How much: _____ For how long: _____
 Quit: _____ How long ago: _____

SPECIAL DIETS: (i.e. milk free, low fat, vegetarian)

EXERCISING:

What exercising do you do? How often? How long at a time? Please include competitive sports.

FRACTURES:

Please list all fractures and their after effects, if any.

HEAD INJURIES:

Please list all head injuries with cause, treatment, after effects, and approximate age.

OTHER MAJOR INJURIES:

Please list all other major injuries remembered.

OTHER DOCTORS:

List all doctors, therapists, etc. that you are currently seeing. (If you are here as a result of an auto accident, you only need to fill this out on the auto accident information page.)

1. _____

2. _____

3. _____

4. _____

5. _____

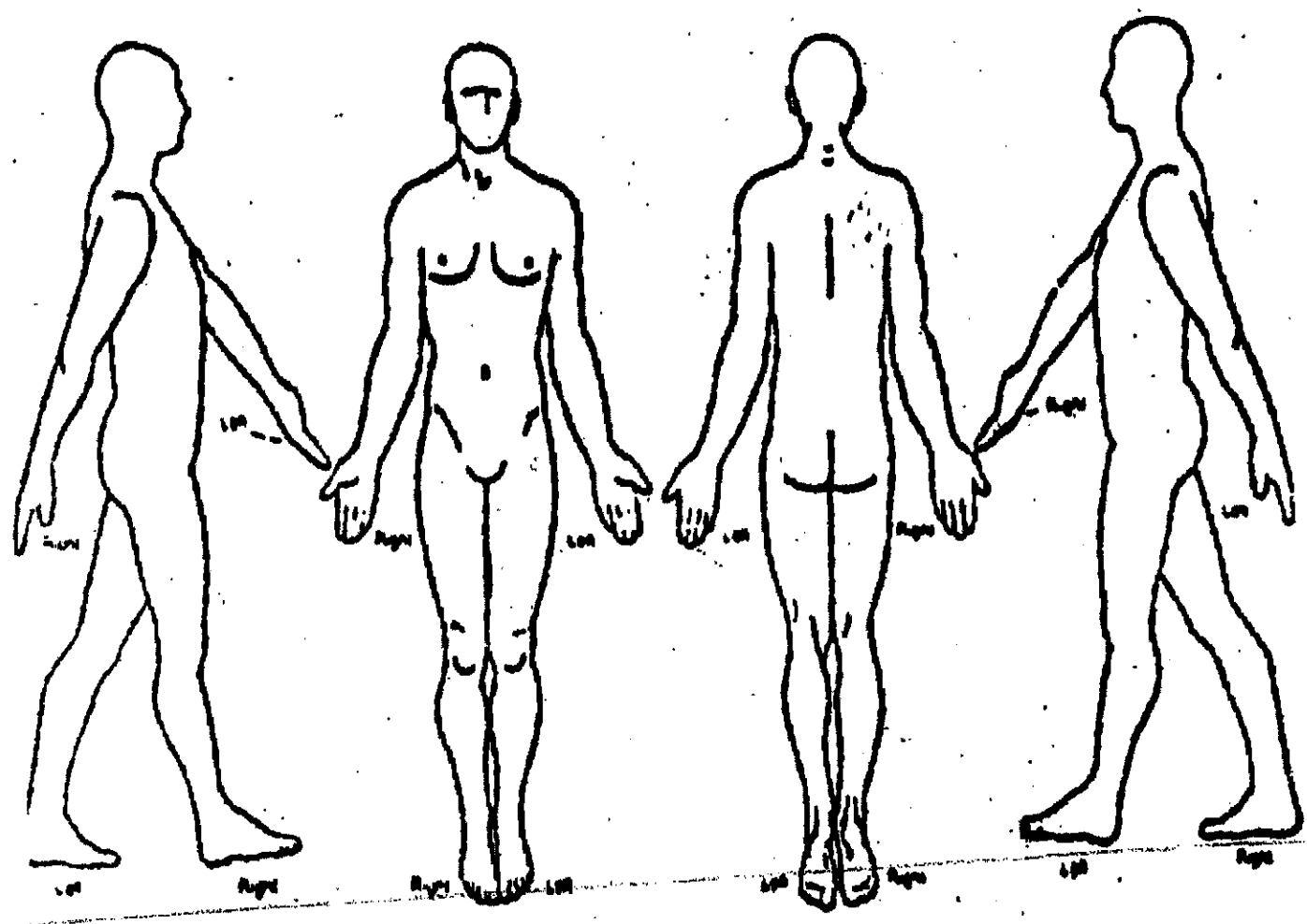
6. _____

Is it possible the pain or injury is related to a specific incident? NO YES, _____

Date of incident: _____

Draw the location and type of your pain on the body outlines and mark how intense the pain is on the scale from 1 to 10 on the bottom of the page.

ACHE BURNING NUMBNESS PINS & NEEDLES STANDING OTHER
///// B B B B B X X X X X - - - - - S S S S S S O O O O



No Pain 1 2 3 4 5 6 7 8 9 10 Intolerable Pain