Mercy

Mercy Integrative Medicine

HEALTH HISTORY

GENERAL
___ Breast Lump
___ Weight Loss/Gain
___ Allergies
___ Anemia
___ Bleeding Disorders
___ Diabetes
___ Cancer/Tumors
___ Thyroid Disease
___ Alcoholism
___ Drug Abuse/Chemical Dependency
___ HIV

EAR, EYE, NOSE & THROAT
___ Poor Vision
___ Deafness/Difficulty Hearing
___ Sinus Problems
___ Hoarseness
___ Tonsillectomy

GASTROINTESTINAL
___ Poor Appetite/Digestion
___ Difficulty Swallowing
___ Belching/Gas
___ Nausea
___ Vomiting
___ Ulcers
___ Black/Bloody Stools
___ Liver Problems
___ Gallbladder Problems
___ Jaundice
___ Hernia
___ Diarrhea/Constipation
___ Appendicitis
___ Anorexia/Bulimia

SKIN
___ Itching
___ Bruising Easily
___ Change in Mole
___ Skin Cancer
___ Scars (Location) _____

_____

RESPIRATORY
___ Chronic Cough
___ Spitting Blood/Phlegm
___ Asthma
___ Emphysema
___ Pneumonia
___ Tuberculosis
___ Bronchitis

CARDIOVASCULAR
___ Irregular Heartbeat
___ High Blood Pressure
___ Heart Disease
___ Ankle Swelling
___ Varicose Veins
___ Rheumatic Fever/Arthritis
___ Stroke
___ High Cholesterol
___ Pacemaker

FAMILY HISTORY
___ Diabetes
___ Thyroid Disease
___ Tuberculosis
___ Kidney Disease
___ High Blood Pressure
___ Heart Disease
___ Cancer
___ Muscle, Bone or Nerve Disease
___ Lung Disease
___ Arthritis
___ Stroke/Seizures
___ Other _____

_____

HABITS
___ Smoking _____ # Pack/Day
___ Drinking
___ Caffeine/Coffee

GENITOURINARY
___ Kidney Disease
___ Frequent/Painful Urination
___ Venereal Disease

NEUROLOGIC
___ Weakness
___ Twitching/Tremors
___ Fainting/Dizziness
___ Headaches (Type) _____

_____
___ Convulsion
___ Epilepsy/Seizures
___ Numbness/Tingling
___ Multiple Sclerosis
___ Pinched Nerve
___ Psychiatric Care
___ Herniated Disk

MUSCULOSKELETAL
___ Neck Stiffness/Pain
___ Low Back Pain
___ Arthritis
___ Osteoporosis
___ Prosthesis
___ Scoliosis
___ Fractures

MEN
___ Prostate Problems

WOMEN
___ Painful Periods
___ Irregular Cycles
___ Vaginal Infections
___ Hot Flashes
___ Miscarriages
___ Date of Last Period _____
___ Date of Last Pap _____

EXERCISE
___ None
___ 1-2 Times/Week
___ 3-5 Times/Week
___ 6-7 Times/Week

Type _____

Surgeries: _____

_____

_____

Falls: _____

_____

_____

Medications: _____

_____

_____

Vitamins/Supplements: _____

_____

_____

Reviewed with patient _____ Date: _____

Physician Signature