 **©Key Areas for a Comprehensive Medical History:**

- Brain Health
- Pulmonary (Lung) Health
- Bone Health
- Cardiovascular Health
- Eye Health
- Elimination Issues (e.g., constipation, diarrhea)
- Joint Health
- Liver and Gallbladder
- Gut Health and Family History
- Sleep Hygiene
- Immunological Health
- Substance Use and Addiction
- Endocrine Health
- Cancer Risk or History of Treatment
- Blood-clotting Disorders
- Chronic Inflammatory Diseases
- Kidney and Urinary Tract Health
- Nutrition/Diet
- Medications (Prescription and Over-the-counter

Sample of a Patient Medical History Form

Personal Information:

- **Name:** [Patient's Name]
- **DOB:** [Date of Birth]
- **Gender:** [Gender]
- **Contact Information:** [Phone, Email]
- **Emergency Contact:** [Name, Relationship, Phone Number]
- **Primary Care Physician:** [Name, Phone Number] (****This is often a missing component but very important in building your network of providers)**

Brain Health:

- Do you have any neurological conditions?
    - e.g., Alzheimer's, dementia, or any other cognitive disorders.
- Do you experience frequent headaches, dizziness, or memory loss?
- Have you ever had a stroke or seizure?
- Doctors contact

Pulmonary (Lung) Health:

- Do you have a history of asthma, COPD, or other lung conditions?

- Do you smoke, or have you ever smoked? How many cigarettes/vaping per day? Are you interested in quitting this habit? Smoking Cessation Counselling could be offered.
- Do you experience shortness of breath, wheezing, or a chronic cough?
- Do you have sleep apnea or use a CPAP machine?
- Doctors contact

Bone Health:

- Have you been diagnosed with osteoporosis, osteoarthritis, or another bone condition?
- Do you experience frequent fractures or bone pain?
- Are you undergoing bone health treatments, such as calcium or bisphosphonates?
- Doctors contact

Cardiovascular Health:

- Have you been diagnosed with high blood pressure, heart disease, or arrhythmia?
- Do you have a history of heart attacks or strokes?
- Are you taking any medications for heart conditions, including blood thinners or statins?
- Doctors contact

Eye Health:

- Do you have a history of eye diseases like glaucoma, macular degeneration, or cataracts?
- Do you wear glasses or contacts?
- Have you noticed any changes in your vision recently?
- Doctors contact

Elimination Issues (e.g., constipation, diarrhea):

- Do you suffer from chronic constipation, diarrhea, or irritable bowel syndrome (IBS)?
- Are you currently being treated for any gastrointestinal conditions, such as Crohn's disease or ulcerative colitis?
- Doctors contact

Joint Health:

- Do you have any joint pain, stiffness, or swelling?
- Have you been diagnosed with conditions like rheumatoid arthritis or osteoarthritis?
- Are you currently taking any medications for joint health, such as NSAIDs or steroids?
- Doctors contact

Liver and Gallbladder:

- Do you have a history of liver disease, gallstones, or gallbladder issues?
- Have you ever had liver function tests, and what were the results?
- Do you experience frequent indigestion, particularly after eating fatty foods?
- Doctors contact

Gut Health and Family History:

- Do you have a history of gastrointestinal conditions such as acid reflux, GERD, or food intolerances?
- Are you experiencing gastrointestinal discomfort, like bloating, heartburn, or nausea?
- Any family history of gastrointestinal diseases, like Crohn's disease or colorectal cancer?
- Doctors contact

Sleep Hygiene:

- Do you have difficulty falling asleep or staying asleep?
- Do you snore, or have you been diagnosed with sleep apnea?
- Do you feel rested when you wake up?
- Have you had a sleep study completed?
- Doctor contact

Immunological Health:

- Do you have a history of autoimmune diseases like lupus, rheumatoid arthritis, or multiple sclerosis?
- Do you experience frequent infections or fatigue?
- Are you taking immunosuppressive medications?
- Doctors contact

Substance Use and Addiction:

- Do you use tobacco, alcohol, or recreational drugs?
- Have you ever been treated for substance use disorder?
- Are you currently seeking treatment or support for addiction?
- Doctors contact

Endocrine Health:

- Do you have a history of thyroid disease, diabetes, or other endocrine disorders?
- Are you currently being treated for any hormone imbalances?
- Do you experience unexplained weight gain or loss, fatigue, or heat/cold intolerance?
- Last Test result: for diabetes A1c_____ Blood Sugar today_____
- Doctors contact

Cancer Risk or History of Treatment:

- Have you been diagnosed with cancer in the past?
- If so, what type of cancer and what treatments have you received (e.g., chemotherapy, radiation)?

- Is there a family history of cancer, particularly head and neck, breast, colorectal, pancreatic, or prostate?
- Doctor contact:

Blood-Clotting Disorders:

- Do you have a history of blood clotting disorders, such as deep vein thrombosis (DVT) or pulmonary embolism (PE)?
- Are you currently taking anticoagulants (blood thinners) like warfarin or aspirin?
- Doctor contact

Chronic Inflammatory Diseases:

- Have you been diagnosed with chronic inflammatory diseases such as psoriasis, rheumatoid arthritis, or inflammatory bowel disease?
- Are you on medication to control inflammation or pain associated with these conditions?
- Doctor Contact

Kidney and Urinary Tract Health:

- Do you have a history of kidney disease, kidney stones, or urinary tract infections (UTIs)?
- Are you experiencing changes in urinary frequency, color, or pain during urination?
- Do you have a family history of kidney disease?

Diet and Nutrition:

- What does your typical daily diet look like? (e.g., meals, snacks)
- Do you follow any specific dietary patterns or restrictions? (e.g., vegetarian, vegan, low-carb, gluten-free, etc.)
- Do you have any food allergies, sensitivities, or intolerances? (e.g., dairy, gluten, nuts, etc.)
- Do you take vitamin or mineral supplements? If yes, which ones?
- How many servings of fruits and vegetables do you consume daily?
- Do you regularly consume processed or fast foods?
- Do you drink sugary beverages or sodas?
- How much water do you drink on a daily basis?
- How many times a week do you consume alcohol, if any?
- Do you consume caffeine regularly (coffee, tea, energy drinks)? If so, how much?
- Have you experienced any changes in your appetite, weight, or eating habits recently?

Medications Prescription and over-the-counter

- What prescription medications are you currently taking?
- Do you take any over-the-counter medications, including vitamins or supplements?
- Are you taking any herbal or alternative treatments?
- Have you recently experienced any changes in your medications or dosages?

Family History:

- **Does anyone in your family (parents, siblings, grandparents) have a history of the following?**
    - Cancer
    - Diabetes
    - Heart disease
    - Stroke
    - Kidney disease
    - Osteoporosis
    - Alzheimer's or other cognitive disorders
    - Autoimmune conditions

Lifestyle and Social History:

- Do you follow a regular exercise routine?
- Do you have a routine for stress management or relaxation?
- Do you get regular preventive health screenings?

Patient's Goals:

- What are your primary health goals or concerns?
- What do you hope to achieve during your visit today?

Signature:

- **Patient's Signature:** _____
- **Date:** _____

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