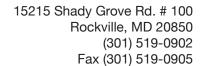


15215 Shady Grove Rd. # 100 Rockville, MD 20850 (301) 519-0902 Fax (301) 519-0905

MEDICAL HISTORY QUESTIONNAIRE

Please list below of	current medica	ations you are ta	aking (incl	uding prescriptions,	over:	the counter n	needs, vitamins, herk	oal supplements):	
1		2			3				
4		E			C				
4		5			O				
Have you ever ha	d or do vou d	currently have:							
Bronchitis		Yes	Aneurysr	n		Yes	Kidney Disease/Failu	ure	☐ Yes
Allergic Rhinitis		Yes	,	s or Recurring Headach	nes 🗖	Yes	Dialysis		☐ Yes
Sinusitis		Yes	Stroke or			Yes	Urinary Tract Infectio	n	☐ Yes
Ear Infection		Yes	Anxiety			Yes	Enlarged Prostate or	· infection	☐ Yes
Emphysema / COPE		Yes	Depressi	on		Yes	Pelvic Infections		☐ Yes
Asthma		Yes	Bipolar Disorder			Yes	Ovarian Cyst		☐ Yes
Lung Disease		Yes	Acid Reflux			Yes	Sexually Transmitted	Disease	☐ Yes
High Blood Pressure		Yes	Heart Burn			Yes	HIV, Hepatitis		☐ Yes
Heart Disease		Yes	Diabetes			Yes	Thyroid Disease		☐ Yes
High Cholesterol		Yes	Peptic UI	cer Disease		Yes	Arthritis		Yes
Inflammation of Vein		Yes	Pancreat	itis		Yes	Gout		Yes
Blood Clots / DVT		Yes	Diverticul	itis		Yes	Artificial Joints		Yes
Bleeding Disorder		Yes	Intestinal	or Colon Problems		Yes	Fibromyalgia		☐ Yes
Fainting		Yes	Gallblado	der Disease / Gallstones	s 🗖	Yes	Back Problems		Yes
Seizures		Yes	Liver Dise			Yes	Skin Disorders		☐ Yes
Anemia		Yes		or Kidney Infection		Yes	Immunizations up to	date?	☐ Yes
Cancer		Yes	Kidney S	tones	☐ Yes				
I have no history of	f significant m	edical problems	☐ Yes						
List any other dise	ases or cond	itions:							
Do you have any a	allorgios? (Env	vironmontal and/	'or modio	ational D. Vac		No			
					_	INO			
				pandages, or topical			orin)? U Yes	□ No	
Are you Pregnant?	Yes 🗖	No	Are you	breastfeeding?	Yes	☐ No			
Surgeries:									
•	Deck Deal	bladdar 🗖 Haart I	D. (0000		Цоло	you had any a	other surgeries? 🔲 Y	∕es □ No	
□ Appendectomy□ Back□ Gallbladder□ Heart Byp□ Hysterectomy□ Pacemaker□ Tonsillectomy			Dypass						
☐ Hysterectomy ☐	Pacemaker u	Ionsillectomy			Pleas	se specify:			
Family Medical H	istory:								
	None	Diabetes		High Blood Pressure		Heart Dis	sease	Other	
Mother									
Father									
Sister									
Brother									
Daughter									
Son									
Social History:									
Do you now or have	vou ever used	alcohol?	☐ Yes	□ No	How	much:			
					much:				
Do you use any drug	ys (ii iciuulii ig Mi	arijuariaj (☐ Yes	□ INO	⊓UW	much:			
Name						Data			





COMPREHENSIVE REVIEW OF SYMPTOMS

Please check boxes that apply to you today:

Constitutional		Genitourinary female	
Loss of appetite	☐ Yes	Painful menstrual cycle	☐ Yes
Fever	☐ Yes	Pelvic pain	☐ Yes
Weakness	Yes	Irregular periods	☐ Yes
		Vaginal itching	☐ Yes
ENT		Abnormal vaginal discharge	☐ Yes
Nose bleeds	Yes		
Sore throat	Yes	Musculoskeletal	
Ear pain	Yes	Joint stiffness	☐ Yes
		Joint pain	☐ Yes
Ophthalmology		Joint swelling	☐ Yes
Drainage from eyes	☐ Yes	Back pain	☐ Yes
Blurring of vision	☐ Yes	Neck pain	☐ Yes
Eye irritation	☐ Yes	Muscle aches	☐ Yes
Cardiology		Dermatology	
Palpitations	☐ Yes	Itching	☐ Yes
Chest pain	☐ Yes		
		Neurology	
Respiratory		Headache	☐ Yes
Shortness of breath	Yes	Tingling/numbness	☐ Yes
Cough	Yes	Dizziness	☐ Yes
Congestion	☐ Yes		
		Hematology / Lymphatic system	
Gastroenterology		Swollen glands	☐ Yes
Diarrhea	☐ Yes	Fatigue	☐ Yes
Vomiting	☐ Yes		
Constipation	☐ Yes	Endocrinology	
Nausea	☐ Yes	Excessive thirst	☐ Yes
Abdominal pain	☐ Yes	Excessive sweat	☐ Yes
		Cold intolerance	☐ Yes
Urology		Heat intolerance	☐ Yes
Difficulty urinating	☐ Yes		
Blood in urine	☐ Yes	Allergy	
Frequent urination	☐ Yes	Runny nose	☐ Yes
Urinary incontinence	☐ Yes	Itchy eyes	☐ Yes
		Sneezing	☐ Yes
		Other	

Name Dat	e
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