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# Follow-UP Visit Medical History

**Appointment Date: ____/____/_____ Patient Name: _____**

***What are your present Top 3 worst complaints?***

**1. 2. 3.**

**Please describe any new problems you are having:**

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## Please List Any Chronic Problems You Have & Their Status:

| Type of Problem | Mild Exacerbation | Progression | No Change | Improvement |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |

**Current Health Status: *Circle any that you are experiencing***

General Health: fatigue, weight loss, weight gain, brain fog

Eyes: Blurred vision, squiggly lines, flashes of light

Ears/Nose/Throat: Ringing in ears, congestion, sore throat

Genitourinary: Frequency, burning with urination

Respiratory: shortness of breath, cough, wheezing

Cardiovascular: Chest pain, swelling of lower legs

Endocrine: cold intolerance, hotflashes, night sweats

Musculoskeletal: muscle aches and pains, muscle cramps

Skin: rashes, changes in color, loss of hair

Neurological: headaches, loss of balance, memory loss

Psychiatric: anxiety attacks, morning depression, apathy

Allergic: hayfever, hives

Lymph/Blood: swollen glands, swelling of hands or legs, bruise easily, bloody nose, blood in stool

Gastrointestinal: nausea, constipation, diarrhea, abdominal pain, bloating, heartburn

## Social History:

- Do you use tobacco? _____ Yes How much per day?_____ _____ No
- Do you use alcohol? _____ Yes How much per day?_____ _____ No
- **Do you use artificial sweeteners?_____ Yes What type?_____ _____ No**
- Please describe your immunization status:
- Occupation:_____Previous Occupations: _____
- Single _____ Married_____ Widowed_____Divorced_____
- Level of education completed:
- Have you traveled outside of the United States recently?

## List any Medical Conditions you have been told you have:

## Surgeries?

**Are you following any specific diet? (please describe:**

**Allergies:** Please list any food or drug allergies below:

**Current Vitamin/Mineral Supplements** **Dosage**

_____

_____

_____

_____

_____

_____

_____

_____

**Current Prescription Medications & Hormones:**

Name Reason for Taking? Dose Date Started

_____

_____

_____

_____

_____

_____

**Do you have a family history of any of the following?**

Uterine cancer _____ No _____ Yes Family member(s) _____
Ovarian cancer _____ No _____ Yes Family member(s) _____
Breast cancer _____ No _____ Yes Family member(s) _____
Other Cancers _____ No _____ Yes Family member(s) _____
Heart disease _____ No _____ Yes Family member(s) _____
Osteoporosis _____ No _____ Yes Family member(s) _____
Diabetes _____ No _____ Yes Family member(s) _____
Hypertension _____ No _____ Yes Family member(s) _____
Allergies/Asthma _____ No _____ Yes Family member(s) _____
Alzheimer's/Dementia _____ No _____ Yes Family member(s) _____

**Please describe the health status or cause of death of parents, siblings or children below:**