NORTHWESTERN MEMORIAL PHYSICIANS GROUP

Center for Integrative Medicine and Wellness
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Name _____ Date Of Birth _____ Date _____

PRESENT ILLNESS

Describe your present medical symptoms: _____

List all allergies - including any drugs (what was the reaction?)

List your current medications (Prescription, nonprescription drugs, birth control pills, supplements and herbs)

Name	Dosage	How many times/day?

PAST MEDICAL HISTORY

(1) Surgeries

Type of Surgery	Date	Where treated?

(2) Previous significant medical problems/hospitalizations

Type of Illness	Date	Where treated?

Did you ever have any problems in the following areas:

- ☐ Asthma
- ☐ Bladder Problems
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Gallbladder Problems
- ☐ Headaches
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ HIV or AIDS
- ☐ Kidney Problems
- ☐ Lg. Intestine Problems
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Menstrual Problems
- ☐ Prostate Problems
- ☐ Sm. Intestine Problems
- ☐ Spleen Problems
- ☐ Stomach Problems
- ☐ Thyroid Problems

FAMILY HISTORY

List any medical problems of the following blood relatives:

Father _____

Mother _____

Siblings _____

Do you have relatives with any of the following illnesses?

	Yes	No	RELATIONSHIP
Heart Attack (age < 65)	☐	☐	_____
High Cholesterol	☐	☐	_____
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Ovarian Cancer	☐	☐	_____
Breast Cancer	☐	☐	_____
Prostate Cancer	☐	☐	_____
Colon Cancer	☐	☐	_____
Skin Cancer	☐	☐	_____
Sickle Cell Disease	☐	☐	_____

SOCIAL HISTORY

Occupation: _____

Current or previous smoker? _____ How much? _____ For how many years: _____ Quit date: _____

Do you drink alcohol? _____ Drinks of wine/beer/hard liquor per day/week: _____

Do you use recreational drugs? _____ If so, what type? _____ Do you exercise regularly? _____

What is your diet? ☐ General ☐ Low Fat ☐ Vegetarian

Do you have any risks for HIV exposure?

☐ Blood transfusion ☐ IV Drug use ☐ Multiple sex partners ☐ NONE

REVIEW OF SYSTEMS

Do you have any unusual:

	Yes	No
Fevers?	☐	☐
Night Sweats?	☐	☐
Chills?	☐	☐
Fatigue?	☐	☐
Have you gained or lost more than 10 pounds in 6 months?	☐	☐

RESPIRATORY	Yes	No
Persistent cough?	☐	☐
Sputum/Phlegm production?	☐	☐
Shortness of breath?	☐	☐
Coughing up blood?	☐	☐

CARDIAC	Yes	No
Do you have any chest pain or discomfort?	☐	☐
Palpitations?	☐	☐

CARDIAC	Yes	No
Shortness of breath w/ minimal activity?	☐	☐
Shortness of breath when lying flat?	☐	☐
Swelling of legs?	☐	☐
Are you ever awakened from sleep with shortness of breath?	☐	☐

GASTROINTESTINAL	Yes	No
Any abdominal pain?	☐	☐
Bloating/Swelling?	☐	☐
Nausea?	☐	☐
Vomiting?	☐	☐
Diarrhea?	☐	☐
Constipation?	☐	☐
Blood in your stools?	☐	☐
Black tarry stools?	☐	☐
Have your bowel habits changed?	☐	☐

NAME: _____

REVIEW OF SYSTEMS (Continued)

URINARY	Yes	No
Any burning with urination?	☐	☐
Too frequent urination?	☐	☐
Awakened from sleep to urinate?	☐	☐
How often? _____		
Any blood in the urine?	☐	☐
Incontinence of urine?	☐	☐
Trouble starting urination?	☐	☐
Any history of STD's?	☐	☐
If so, what kind of STD? _____ (Gonorrhea, Chlamydia, Syphilis, Genital Warts, Herpes, and HPV).		

NEUROLOGIC		
Any unusual headaches?	☐	☐
Loss of vision or double vision?	☐	☐
Weakness or numbness in the arms or legs?	☐	☐
Dizziness?	☐	☐

MUSCULOSKELETAL

- ☐ Bone or joint disease _____
- ☐ Tendonitis _____
- ☐ Bursitis _____
- ☐ Bone Fractures _____
- ☐ Arthritis _____
- ☐ Sprains _____
- ☐ Headaches/Head Injuries
- ☐ TMJ/Jaw Pain
- ☐ Herniated/Slipped Disk _____
- ☐ Low Back/Hip/Leg Pain _____
- ☐ Neck/Shoulder/Arm Pain _____

	Yes	No
Any persistent joint ache or swelling?	☐	☐
Which joints involved? _____		

GYNECOLOGICAL	Yes	No
Total pregnancies? _____		
Any miscarriages?	☐	☐
Abortions?	☐	☐
Do you have breast implants?	☐	☐
Date of your last menstrual period? _____		
Are your periods regular?	☐	☐
Do you menstruate excessively?	☐	☐
Unusual vaginal discharge or bleeding?	☐	☐

GYNECOLOGICAL	Yes	No
Are you in menopause?	☐	☐

What type of birth control method do you use? _____
When was your last pap smear? _____
When was your last mammogram? _____

DIGESTIVE

How many meals do you eat per day? _____
How would you describe your appetite (excellent, good, fair, poor)? _____
Describe any cravings _____
Describe any aversions _____
Briefly describe your diet: _____

	Yes	No
Do you have any restrictions?	☐	☐
Food Allergy?	☐	☐
Hypoglycemia?	☐	☐

MENTAL HEALTH	Yes	No
1. Do you feel you have control over your life?	☐	☐
2. Do you have low energy?	☐	☐
3. Do you have chronic problems with sleep?	☐	☐
4. Do you have a difficult time dealing with your chronic illness or illness of your family member/significant other?	☐	☐
5. Are you experiencing conflict with interpersonal relationships?	☐	☐
6. Has there ever been conflict with spiritual oneness?	☐	☐
7. Have you felt irritable, tense or anxious over the past week?	☐	☐
8. Have you felt sad or blue over the past week?	☐	☐
9. Do you use substances (alcohol, caffeine, pills) to help you cope with difficult situations?	☐	☐

EXERCISE

Do you exercise regularly? _____
What type of exercise? _____
When do you exercise? _____
How long do you exercise? _____
Do you meditate? _____
How often do you meditate? _____

Do you have any symptoms not described above? _____

MUSCULOSKELETAL PAIN INVENTORY (if applicable)

When did your symptoms appear? _____

Is the condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Where are you feeling pain, numbness, or tingling? _____

_____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it consistant or does it come and go? _____

Does it interfere with your:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

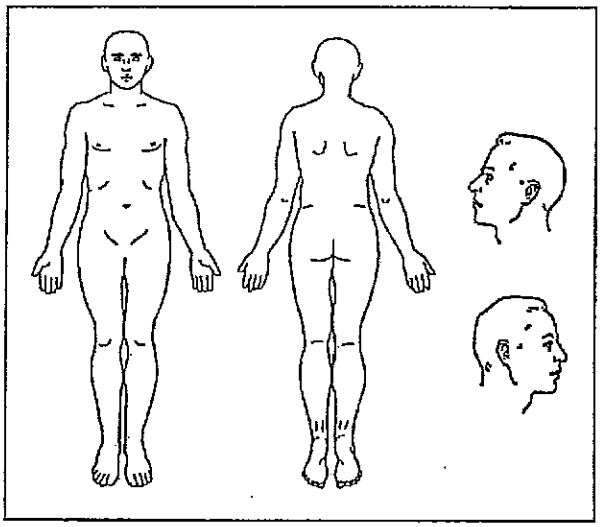
Activities or movements that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking
☐ Bending ☐ Stretching

Have you seen a doctor about it?

☐ Yes ☐ No Name of doctor: _____

Did you have an x-ray? ☐ Yes ☐ No



(Mark the origin of your pain)