BRAZOS
INTEGRATIVE MEDICINE

Patient Medical History

Today's Date: _____

Patient Name: _____ Date of Birth: _____

PATIENT HISTORY

No Past Conditions ☐

CHECK ANY CONDITIONS YOU ARE CURRENTLY BEING TREATED FOR OR HAVE HAD IN THE PAST:

☐ Heart disease	☐ Anemia or other blood disease	☐ Severe headaches	☐ Neck pain
☐ High blood pressure	☐ Thyroid disease	☐ Seizures	☐ Back pain
☐ High cholesterol	☐ Stomach disease	☐ Stroke	☐ Sleep apnea
☐ Lung disease	☐ Kidney, bladder or prostate disease	☐ Blood clots	☐ _____
☐ Diabetes	☐ Cancer (past or present)	☐ Depression	

ALLERGIES (include medication, food, latex and environmental allergies)

No Known Allergies ☐

Allergy to:	1. _____	2. _____	3. _____
Severity:	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe	☐ Mild ☐ Moderate ☐ Severe
Reaction:	_____	_____	_____

CURRENT MEDICATION (include non-prescription products)

No Current Medication ☐

1. _____	3. _____	5. _____	7. _____
2. _____	4. _____	6. _____	8. _____

PREFERRED PHARMACY

Pharmacy Name: _____ Location: _____

PROCEDURES/SURGERIES

Approximate Date	Surgery	Approximate Date	Surgery

PREVENTATIVE SCREENING

Have you had a colonoscopy?	☐ Yes ☐ No	If yes, date:	_____
Have you had a mammogram?	☐ Yes ☐ No	If yes, date:	_____
Have you had a Pap Smear?	☐ Yes ☐ No	If yes, date:	_____
Have you had a Chest X-ray?	☐ Yes ☐ No	If yes, date:	_____
Have you had a EKG?	☐ Yes ☐ No	If yes, date:	_____
Have you had a Hearing and Vision Test?	☐ Yes ☐ No	If yes, date:	_____
Have you had a Bone Density?	☐ Yes ☐ No	If yes, date:	_____

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FAMILY HISTORY

Mother:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Father:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Sister:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Brother:	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (M):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandmother (P):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (M):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A
Grandfather (P):	☐ High Blood Pressure	☐ Diabetes	☐ Cancer	☐ Other (please specify) _____	☐ N/A

OTHER HEALTH ISSUES

Do you drink alcohol? ..... ☐ Yes ☐ No ☐ Beer ☐ Wine ☐ Liquor _____ per week

Do you smoke cigarettes? ..... ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Do you use other forms of tobacco? ..... ☐ Yes ☐ No ☐ Pipe ☐ Cigar ☐ Snuff/Chew

Do you use an e-cigarette? ..... ☐ Yes ☐ No If yes, _____ per day, _____ years of use

Marijuana / recreational drug use? ..... ☐ Yes ☐ No If yes, _____ per day, _____ years of use

IMMUNIZATIONS

Influenza (18 years of age and older)? ..... ☐ Yes ☐ No If yes, date: _____

Pneumoccal (65 years of age and older)? ..... ☐ Yes ☐ No If yes, date: _____

Tetanus? ..... ☐ Yes ☐ No If yes, date: _____

WOMEN'S HEALTH

When was your last menstrual cycle? Date: _____

Period every _____ Days

Heavy/Irregularity/Spotting/Pain/Discomfort? _____

Age at onset of menstration? _____ Number of births: _____

Pregnant or Breastfeeding? _____

Hot Flashes/Sweating at night? _____

Menstral tension, pain, bloating, irritability, or other symptoms at time of period? _____

Any blood in Urine? _____

Any problems with control of urination? _____

Any bladder or kidney infections in the last year? _____

Date of last pap and rectal exam? Date:

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MEN'S HEALTH

How many times do you urinate during the night? _____ Do you feel pain/burning with urination? _____
Any blood in Urine? _____ Have you had any kidney, bladder or prostate infection within the past 12 months? _____
Do you have problems emptying your bladder completely? _____ Has the force of your urination decreased? _____
Any difficulty with erection or ejaculation? _____ Any testicle pain or swelling? _____
Date of last prostate and rectal exam? ____ / ____/ ____

Review of Systems - Please Circle all that apply (past or present)

General/Constitutional:
Fatigue, Fever, Sleep Disturbance, Weight Gain, Weight loss
Allergy/Immunology:
Seasonal Allergies
Ophthalmolgic:
Blurred Vision, Itching, Eye Pain, Redness
ENT:
Decreased Hearing, Ear Pain, Nosebleed, Sinus Pain, Sore Throat, Swollen Glands
Endocrine:
Cold Intolerance, Sleep Difficulty, Excessive Thirst, Hair Loss
Respiratory:
Cough, Hemoptysis, Shortness of Breath, Wheezing
Cardiovascular:
Chest Pain, Heart Problems, Irregular Heartbeat, Palpitations, Swelling in Hands or feet
Gastrointestinal:
Abdominal Pain, Blood in Stool, Constipation, Diarrhea, Heartburn, Nausea Vomitting

Hematology:
Anemia, Bleeding Problems, Easy Bruising, Swollen Glands
Genitourinary:
Blood in Urine, Difficulty with Urination, Frequent Urination, Painful Urination
Musculoskeletal:
Back Problems, Joint Stiffness, Muscle Aches
Peripheral Vascular:
Cold Extremities, Painful Extremities
Skin:
Blistering of Skin, Dry Skin, Itching, Nail Changes
Neurologic:
Balance Difficulty, Dizziness, Headache, Memory Loss, Tingling/Numbness
Psychiatric:
Anxiety, Depressed Mood, Difficulty Sleeping
Cancer Management:
Breast Self-Exam, Colonoscopy, Mammogram, PAP, PSA, Skin Exam, Smoking Cessation

Recreational Drug Use
_____ Never Use
_____ Previous Use of
_____ Currently use:
_____

Any history of IV drug use?
____ Yes
____ No

If yes, please answer the following:

What Drug:
_____
Last Used:
_____

Current Symptoms

Indicate if you have, or have had, any symptom(s) in the following areas to a significant degree and briefly explain.

Skin _____ Back _____ Headache _____
Head/Neck _____ Intestinal _____ Difficulty Sleeping_____
Ears _____ Bladder _____ Depression _____
Nose _____ Bowel _____ Anxiety _____
Throat _____ Circulation _____ Other Pain/Discomfort:
Lungs _____ Change in Weight _____
Chest/Heart _____ Change in Energy Level _____
Breast _____ Dizziness _____

Misc

Religious/Cultural Beliefs
Do you have any religious/cultural practices which restrict the foods you eat or the medical treatment you receive? _____

Special Learning or Communication Needs? _____
_____
_____

Have you ever had a blood transfusion? Yes ☐ No ☐