



Patient Medical History

Check if you have experienced, or are currently experiencing, the following conditions:

Constitutional		
<input type="checkbox"/> Unusual weight gain and/or loss	<input type="checkbox"/> Weakness	<input type="checkbox"/> Fatigue
<input type="checkbox"/> Fever		

Eyes		
<input type="checkbox"/> Pain	<input type="checkbox"/> Redness	<input type="checkbox"/> Excessive tearing
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Double vision
<input type="checkbox"/> Vision problems	<input type="checkbox"/> Glasses or contacts	Date of Last Eye Exam: _____

Ears, Nose, Mouth, Throat		
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Tinnitus (ringing in ears)	<input type="checkbox"/> Vertigo (room spins around)
<input type="checkbox"/> Earaches	<input type="checkbox"/> Infections	<input type="checkbox"/> Discharge
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Nasal stuffiness	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Sinus troubles	<input type="checkbox"/> Bleeding gums
<input type="checkbox"/> Sore tongue	<input type="checkbox"/> Frequent sore throats	<input type="checkbox"/> Hoarseness
<input type="checkbox"/> Lumps in neck	<input type="checkbox"/> Swollen glands	Date of Last Dental Exam: _____
<input type="checkbox"/> Goiter (enlarged thyroid)	<input type="checkbox"/> Other (Please specify): _____	

Cardiovascular		
<input type="checkbox"/> Heart trouble	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Heart murmurs	<input type="checkbox"/> Dyspnea (difficulty breathing)	<input type="checkbox"/> Edema (swelling)
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Hay Fever
<input type="checkbox"/> Orthopnea (having to sleep on more than one pillow to breathe)		
<input type="checkbox"/> Paroxysmal dyspnea (sudden difficulty in breathing)	<input type="checkbox"/> Other (Please specify): _____	



Check if you have experienced, or are currently experiencing, the following conditions:

Respiratory		
<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Colored Sputum	<input type="checkbox"/> Hemoptysis (bloody sputum)
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Date of last chest x-ray: _____	

Gastrointestinal		
<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Changes of appetite
<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Vomiting of blood
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Frequent bowel movements	<input type="checkbox"/> Changes in bowel habits
<input type="checkbox"/> Rectal bleeding	<input type="checkbox"/> Black tarry stools	<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Food intolerance
<input type="checkbox"/> Excessive belching	<input type="checkbox"/> Excessive passing of gas	<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Liver issues	<input type="checkbox"/> Gall bladder issues
<input type="checkbox"/> Hepatitis		

Genitourinary		
<input type="checkbox"/> Polyuria (urinating frequently)	<input type="checkbox"/> Nocturia (getting up frequently to urinate at night)	
<input type="checkbox"/> Dysuria (painful urination)	<input type="checkbox"/> Hematuria (blood in urine)	<input type="checkbox"/> Urgency to urinate
<input type="checkbox"/> Hesitancy to urinate	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Urinary infections
<input type="checkbox"/> Stones		

Integumentary		
<input type="checkbox"/> Rashes	<input type="checkbox"/> Lumps	<input type="checkbox"/> Itching
<input type="checkbox"/> Dryness	<input type="checkbox"/> Color change in skin	<input type="checkbox"/> Changes in hair or nails



Check if you have experienced, or are currently experiencing, the following conditions:

Neurological		
<input type="checkbox"/> Fainting	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Seizures
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Local weakness	<input type="checkbox"/> Numbness
<input type="checkbox"/> Tingling	<input type="checkbox"/> Tremors	<input type="checkbox"/> Memory problems

Psychiatric		
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Tension	<input type="checkbox"/> Moodiness
<input type="checkbox"/> Depression		

Endocrine		
<input type="checkbox"/> Thyroid issues	<input type="checkbox"/> Heat or cold intolerance	<input type="checkbox"/> Excessive sweating
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> Excessive hunger
<input type="checkbox"/> Excessive urination		

Hematologic/Lymphatic		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Bruises easily	<input type="checkbox"/> Bleeds easily
<input type="checkbox"/> Past transfusions (adverse reactions)	<input type="checkbox"/> Cervical lymphadenopathy (swelling in the neck)	
<input type="checkbox"/> Supraclavicular lymphadenopathy (swelling around collar bone)		
<input type="checkbox"/> Axillary lymphadenopathy (swelling under armpits)	<input type="checkbox"/> Inguinal lymphadenopathy (swelling in groin)	

Allergic/Immunologic		
<input type="checkbox"/> Seasonal allergies	<input type="checkbox"/> Immune deficiency diseases	

Musculoskeletal		
<input type="checkbox"/> Joint pains	<input type="checkbox"/> Joint stiffness	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Gout	<input type="checkbox"/> Muscle pains	<input type="checkbox"/> Muscle cramps
<input type="checkbox"/> Neck aches	<input type="checkbox"/> Arm aches	<input type="checkbox"/> Back aches
<input type="checkbox"/> Leg aches		



Phillip A. Wong, D.O., C.S.P.O.M.M.

Osteopathic Manipulative Medicine

3620 Wyoming Blvd., N.E., #128, Albuquerque, NM 87111

(505) 296-8968

Additional Space For Further Explanations:

Signature of Patient/Responsible Party

Date:

Name of Patient/Responsible Party (please print)

Relationship to Patient