Medical History Please mark all that apply.

GENERAL

☐ Fevers/Chills
☐ Peculiar tastes or smells
☐ Cancer
☐ Dream Disturbed Sleep
☐ Change in Appetite
☐ Fatigue
☐ Poor Sleep/ Insomnia
☐ Bleeding or Bruising
☐ Seizures/Tremors
☐ Day/Night Sweats
☐ Weight Loss/Gain
☐ Strong thirst for hot/ cold drinks
☐ Sudden energy drops?
What time of Day? ______
☐ Emotional Changes
☐ Poor Appetite

CARDIOVASCULAR

☐ High/Low blood pressure
☐ Difficulty in Breathing
☐ Chest pain
☐ Swelling of Hands
☐ Palpitations
☐ Swelling of Feet
☐ Blood Clots
☐ Cold Sweats
☐ Pace Maker/Defibrillator
☐ Irregular heartbeat
☐ Cold Hands/Feet
☐ Phlebitis

GASTROINTESTINAL

☐ Nausea/Vomiting
☐ Constipation/Diarrhea
☐ Bad Breath
☐ Abdominal Pain/ Cramps
☐ Indigestion
☐ Blood in Stools
☐ Digestive Disorders
☐ Belching
☐ Hernia
☐ Parasites
☐ Ulcers
☐ Hemorrhoids

GENITO-URINARY

☐ Pain on Urination
☐ Blood in Urine
☐ Incontinence
☐ Erectile Dysfunction
☐ Decrease in Urine
☐ Waking up to Urinate
How often? ______________________
☐ Rashes/Itching
☐ Kidney stones
☐ Frequent Urination
☐ HSV (Herpes Simples Virus)
☐ Discharge
☐ Urgent Urination
☐ Impotency/ Infertility
☐ Prostate Problems
☐ Low Sperm Count

MUSCULOSKELETAL

☐ Arthritis
☐ General Aches
☐ Injuries or Falls
☐ Joint Pain/Instability
☐ Metal/Hardware
where?________________________
☐ Muscular Atrophy
☐ Muscle Cramps
☐ Muscular Weakness/Spasms
☐ Recent Sprains

NEUROPSYCHOLOGICAL

☐ Seizures
☐ Poor Memory
☐ Migraines/Headaches
☐ Areas of Numbness
☐ Dizziness/Fainting
☐ Disorientation
☐ Concussion
☐ Loss of/Poor Balance
☐ Mania/Easily Angered
☐ Lack of Coordination
☐ Depression/Anxiety
☐ Stress

PREGNANCY & GYNECOLOGY

____ Age at First Menses
____ Period between Menses
____ Duration of Menses
☐ Fertility Problems
☐ Difficult Births
_____ Number of Pregnancies
_____ Number of Births
_____ Miscarriages
_____ Abortions
☐ Breast Lumps
☐ Birth Control? *Yes* *No*
What type? ______________
How long? _______________
☐ Vaginal Discharge
☐ Painful Periods
☐ Heavy or Irregular
☐ Clots
☐ Light
☐ PMS

RESPIRATORY

☐ Cough
☐ Bronchitis
☐ Coughing Blood
☐ Pain w/ Deep Breaths
☐ Shortness of Breath
☐ Production of phlegm What Color? ________________
☐ Easily Winded w/ Exertion
☐ Difficulty in Breathing when laying down
☐ Asthma

Please give us any details regarding **hospitalizations**: ____

____

Please give us any details regarding **surgeries**: ____

____

Please give us any details regarding **significant traumas**: ____

____

Antacids	*Currently* __	*Occasionally* ___	Herbs	*Currently* __	*Occasionally* ___
Antihistamines	*Currently* __	*Occasionally* ___	Ibuprofen	*Currently* __	*Occasionally* ___
Aspirin	*Currently* __	*Occasionally* ___	Laxatives	*Currently* __	*Occasionally* ___
Blood Thinners	*Currently* __	*Occasionally* ___	Oral contraceptives	*Currently* __	*Occasionally* ___
Cardiac Medications	*Currently* __	*Occasionally* ___	Sleeping pills	*Currently* __	*Occasionally* ___
Cold tablets	*Currently* __	*Occasionally* ___	Tranquilizers	*Currently* __	*Occasionally* ___
Diet pills	*Currently* __	*Occasionally* ___	Vitamins	*Currently* __	*Occasionally* ___

I hereby authorize the above mentioned Integrative Services to be provided by the Spaulding Rehabilitation Hospital Network Clinicians. I know the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me to as to the result of treatment(s) or examinations. If I experience any pain or discomfort during treatment, I will immediately inform the practitioner, so treatment can be adjusted. I affirm that I have stated all known medical conditions and answered all questions honestly. I realize that the Integrative Medicine Service is a self-pay program and I will provide payment at the time of visit.

Signature____ **Date** __________________________________

PLEASE COMPLETE BOTH SIDES