Center for Holistic Medicine

Frequency Specific Microcurrent

New Patient Medical History Form

Preferred Name: _____ Date: _____

What Pharmacy do you use? _____

Were you referred to our office? (please circle one) Yes or No

If yes, by whom? _____

Review of Medical Symptoms:

Currently do you have any complaints with the following. (*Please answer yes or no and complaint).*

Constitutional: Fatigue, _____ Weight change, _____ Fever, _____

Eyes: (Y/N) _____ Ear/Nose/Throat: (Y/N) _____ Cardiovascular (heart): (Y/N) _____

Skin: (Y/N) _____ Neurologic: (Y/N) _____ Respiratory (breathing): (Y/N) _____

Psychiatric: (Y/N) ____ Gastrointestinal: (Y/N) _____ Endocrine: (Y/N) _____

Allergies: (Y/N) _____ Genitourinary: (Y/N)_____ Musculoskeletal: (Y/N)_____

Heme/Lymphatic: (Y/N) ____

(bleeding, bruising etc.)

Medical Allergies:

Do you have a Latex Allergy? (Circle one) Yes / No

Please list all known allergies to medications and your reactions:

_____
_____
_____
_____

Patient Name: _____ *Date:* _____

Medical History:

Have you ever been hospitalized: If yes when and why?

_____
_____

Please list any current or past medical conditions you have been diagnosed with:

_____
_____

Have you ever been diagnosed with Cancer? If yes, when, type and treatment?

_____
_____

Have you ever been diagnosed with HIV/Hepatitis/Etc. Yes / No

If yes, what? _____

Past Surgical History:

Have you ever had surgery? If yes What type and When?

_____
_____

Have you ever had any procedures or surgeries for your heart? If yes what? _____

Medications:

Please list all medication that you currently take including vitamins and non-prescription or alternative medications, the dose and frequency:

_____
_____
_____
_____
_____
_____

Name: _____ Date: _____

Have you ever had any complication with Anesthesia? Yes / No If yes, what?

_____

_____

Do you have a bleeding disorder or difficulty stopping bleeding? Yes / No _____

Family Medical History:

Does any member of your immediate family (parents/siblings/children) have or have ever been treated for the following please put Y/N & who?

Bleeding Disorder: _____

Complication with Anesthesia: _____

High Blood Pressure: _____

Asthma/Emphysema: _____

Heart Disease: _____

Cancer: (Type, Date, & Treatment) _____

Social History:

Marital Status: Single/Married/Divorced/ widowed Number of Children_____

Who lives at home with you? _____

Your Occupation: _____

Do you use or have you ever used Cigarettes/Cigars/Tobacco/Vape? Yes / No

Amount per day: _____ How many years? _____ Year Quit: _____

Do you drink Alcohol? Yes / No Drinks per Day: _____ Type: _____

Do you or have you ever abused drugs: Y/N Type: _____

Please Circle one: Ethnicity: African American, Asian, Caucasian, Hispanic, Other

Primary Language Spoken: _____