

VINEYARD COMPLEMENTARY MEDICINE

MEDICAL HISTORY

Please fill out this questionnaire carefully. The information provided will assist in creating a complete health profile for you.
All of your answers are completely confidential.

Name _____ Date _____ Referred by _____ Email address _____

Mailing Address: local _____ Mailing address: off island (if applicable) _____

City _____ State/Zip _____ City _____ State/Zip _____

Date of Birth (month/day/year) _____ Age _____ Social Security number _____

Phone: Home _____ Cell _____ Work _____

In case of emergency: notify _____ Phone _____

Primary care physician _____ Phone _____

Referring physician _____ Phone _____

Main Complaint (symptoms, diagnosis, how long you have had condition, etc.) _____

Pain level 0 1 2 3 4 5 6 7 8 9 10 How often? _____ What does it feel like? _____

What makes it better? _____ What makes it worse? _____

Prior treatment for this condition: _____ What was helpful? _____

Limitations in activities: _____ Surgeries/Date: _____

Other musculoskeletal issues _____

Significant Trauma (auto accidents, falls, etc.): _____

Allergies (drugs, foods, chemical, environment): _____

Medications: (names and dosage) Vitamins/Supplements/Herbs: /please attach an additional page if necessary: _____

Exercise: Days per week: _____ Length of workout: _____ Type of activity: _____

Other past time activities _____

Other pertinent past medical history:

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Cardiac problems | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Pregnant | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Autoimmune issues |
| <input type="checkbox"/> History of falling | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Weakness | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Lyme's Disease | <input type="checkbox"/> GI problems | <input type="checkbox"/> Emotional issues | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Other (please list) _____ | | | |

Additional info _____

