Balance in Life, P.L.C.

Manual Medicine & Medical Acupuncture
Thaddeus P. Srutwa, M.D.

PATIENT INFORMATION & MEDICAL HISTORY FORM

(Please Print Clearly)
NAME:_____DATE OF BIRTH:_____
HOME PHONE:_____WORK PHONE:_____
CHIEF COMPLAINT(S)_____

MEDICAL HISTORY

(Please check where appropriate)

RINGING IN EARS	CONSTIPATION/DIARRHEA	HEADACHES	**FEMALES**-please complete
EAR INFECTIONS	BLOODY STOOLS	MIGRAINES	PREGNANT-YES….NO…..
DIZZINESS	TARRY STOOLS	ARTHRITIS	PLANNING PREGNANCY?
FAILING VISION	URINATION PROBLEMS	OSTEOPOROSIS	# OF PREGNANCIES……....
SINUS TROUBLE	URINARY INCONTINENCE	BACK PAIN	# MISCARRIAGES……...
HAYFEVER/ALLERGIES	KIDNEY STONES	JOINT INJURIES	# ABORTIONS……
PNEUMONIA	CHRONIC FATIGUE	BONE INJURIES	PERIODS REGULAR?.....
CHRONIC COUGH	ANEMIA	GOUT	PERIODS IRREGULAR?.....
CHEST PAIN	CANCER	FOOT PAIN	BIRTH CONTROL?.....
HIGH BLOOD PRESSURE	DIABETES	NUMB FEET	MENOPAUSAL?.....
LEG PAIN W/ WALKING	THYROID DISEASE	COLD FEET	-IF SO, LAST PERIOD?.....
PERIPHERAL NEUROPATHY	SEIZURE DISORDER	RASHES/HIVES	
PHLEBITIS	STROKE	MEMORY LOSS	
INDIGESTION	TREMOR/HANDS SHAKING	DEPRESSION	ADDITIONAL HISTORY?
REFLUX ESOPHAGITIS	MUSCLE WEAKNESS	MENTAL ILLNESS	-
STOMACH ULCERS	MUSCLE PAIN	PROSTATE DISEASE	-
ABDOMINAL PAIN	NUMBNESS/TINGLING SENSATIONS		-

REVIEW OF SYSTEMS

(Please check if symptomatic with any of these organ systems. If not sure, place question mark and this will be discussed during history taking session with physician.)

SKIN & LYMPH NODES_____	GENITAL & URINARY TRACT_____	HEART & BLOOD VESSELS_____
HEAD & NECK_____	MUSCULOSKELETAL SYSTEM____	RESPIRATORY TRACT_____
THYROID & ENDOCRINE____	CENTRAL NERVOUS SYSTEM_____	GASTROINTESTINAL TRACT____

FAMILY HISTORY

MOTHER_____ EDUCATION_____
FATHER_____ EMPLOYMENT_____
SIBLINGS_____ RELATIONSHIPS_____

HABITS

(Please check where appropriate)

ALCOHOL: TYPE_____	TOBACCO USE_____	CAFFEINE INTAKE/DAY_____	EXERCISE ROUTINE_____
AMOUNTS_____	AMOUNTS_____	SOFT DRINKS/DAY_____	_____
DIET_____	HOW LONG?_____	EXERCISE?_____	_____

MEDICATIONS/SUPPLEMENTS

MEDICATIONS_____
_____
_____
MEDICATION ALLERGIES_____
SUPPLEMENTS_____
_____
(Please use additional sheet if necessary)

HOSPITALIZATIONS & SURGERIES

PLEASE USE THIS SPACE FOR ANY ADDITIONAL INFORMATION IF NECESSARY TO LIST FURTHER HISTORY DATA.

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