JOHN-KENYON

CONFIDENTIAL

Patient Name: ______________________ Date: ______________

PLEASE FILL OUT THIS "COMPREHENSIVE HEALTH HISTORY"
Review of Systems

Constitutional Systems: Fatigue ❒ Yes ❒ No
Fever ❒ Yes ❒ No
Night Sweats ❒ Yes ❒ No
Other ______________________

Head/Ear/Neck/Throat: Hearing Loss ❒ Yes ❒ No
Other ______________________

Respiratory: Cough ❒ Yes ❒ No
Wheezing ❒ Yes ❒ No
Other ______________________

Cardiovascular: Chest Pressure or Discomfort ❒ Yes ❒ No
Irregular heart beat/palpitations ❒ Yes ❒ No
Other ______________________

Gastrointestinal: Constipation ❒ Yes ❒ No
Diarrhea ❒ Yes ❒ No
Vomiting ❒ Yes ❒ No
Other ______________________

Genitourinary: Dysuria (Difficult or Painful Urination) ❒ Yes ❒ No
Hematuria (Blood in the Urine) ❒ Yes ❒ No
Other ______________________

Metabolic/Endocrine: Cold Intolerance ❒ Yes ❒ No
Heat Intolerance ❒ Yes ❒ No
Polydispsia (Excessive Thirst) ❒ Yes ❒ No
Polyphagia (Excessive Hunger) ❒ Yes ❒ No
Polyuria (Frequent Urination) ❒ Yes ❒ No
Other ______________________

Neurological: Dizziness ❒ Yes ❒ No
Headache ❒ Yes ❒ No
Other ______________________

Psychiatric: Emotional Changes ❒ Yes ❒ No
Other ______________________

Integumentary (Skin): Rash ❒ Yes ❒ No
Other ______________________

Musculoskeletal: Arthralgias (Joint Pain) ❒ Yes ❒ No
Gait Disturbance (Trouble Walking) ❒ Yes ❒ No
Joint Swelling ❒ Yes ❒ No
Muscle Weakness ❒ Yes ❒ No
Other ______________________

Hematological/Lymphatic (Blood /Lymph): Bleeding ❒ Yes ❒ No
Bruising ❒ Yes ❒ No
Other ______________________

Immunologic/Allergy: Enviornmental Allergies ❒ Yes ❒ No
Food Allergies ❒ Yes ❒ No
Other ______________________

DRUG ALLERGIES

Do you have allergies to medications: ❒ Yes ❒ No

Please List
____
____
____
____
____

Do you have allergies to:
Latex: ______________
Iodine: ______________

❒ No known drug allergies

PAST MEDICAL HISTORY

Major illness or injuries:
Diabete ❒ High Blood Pressure ❒
____
____
____
____
____

Surgeries:
____
____
____
____
____
____

History of anesthesia problems with yourself or blood relatives ❒ Yes ❒ No

Medications

Name	Strength	Frequency

List any herbs taking:
____
____
____

Social History:

Occupation ______________ Tobacco use? ❒ Yes ❒ No ❒ Former
Alcohol use? ❒ Yes ❒ No ❒ Former Recreational drugs? ❒ Yes ❒ No ❒ Former

Family History:

Blindness ❒ Yes ❒ No
Cancer ❒ Yes ❒ No
Crossed Eyes ❒ Yes ❒ No
Diabetes ❒ Yes ❒ No
Glaucoma ❒ Yes ❒ No
Heart Disease ❒ Yes ❒ No
Retinal Detachment ❒ Yes ❒ No
Health of Parents, Children or Siblings
❒ Good ❒ Poor ❒ Other ______________

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Dr. Review Date

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Dr. Review Date