

# Medical History

**Privacy:** In accordance with the Osteopaths' Code of Professional Conduct, the confidentiality of your information is strictly maintained. Your records are stored securely, and information about you will not be divulged without your permission (unless required by law).

- Mr    Mrs    Other...  
 Ms    Dr  
 Miss    Prof

**Given Name**

**Family Name**

.....

**Street address**

.....

.....

**Suburb or town**

**Postcode**

.....

**Home phone**

**Work phone**

.....

**Mobile**

**Email**

.....

**Date of birth**

.....

**How much exercise, and of what type, do you take per week?**

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**Daily activities (e.g. occupation, sports, hobbies)**

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**What significant accidents have you had, and when were they?**

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**When have you been in hospital, and what were you there for? (Please include giving birth.)**

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**Have you had any major illnesses, and if so, what and when were they?**

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**What medications are you on or have you been taking recently? Have you previously been on any long-term medication?**

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**Have you had any dental work in the past two months?**

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**Do you smoke?**

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**How would you describe your diet? Is there anything you don't eat?**

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**What conditions run in your family? (e.g. high blood pressure, heart conditions, cancer, diabetes, arthritis)**

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# Medical History

## Do you, or have you recently, suffered from any of the following?

### Musculo-skeletal system

- Lower back pain    Upper back pain    Shoulder pain    Other joint stiffness    Deep bone pain  
 Mid back pain    Neck pain    Other joint pain    Joint swelling    Other...

### Cardio-vascular system

- Chest pain    Racing or irregular heart beat    Cold or blue fingers  
 Fainting or loss of consciousness    Shortness of breath    Changes to finger nails  
 High blood pressure    Fluid retention or ankle swelling    Other...

### Respiratory system

- Pain on breathing    Persistent or recurrent sore throats    Sinus pain  
 Persistent cough    Ear aches or ear infections    Sinus congestion  
 Persistent or frequent colds or respiratory infections    Asthma    Other...

### Reproductive system (women)

- Painful periods    Difficulty conceiving    Are you or could you be pregnant?  
 Unusual bleeding    Miscarriage    Other...  
 Irregular periods    Pain or difficulty on intercourse

### Reproductive system (men)

- Difficulty achieving or maintaining erection    Lump in testicle    Other...  
 Pain in testicles    Diminished fertility

### Urinary system

- Pain on urination    Difficulty starting flow or incomplete emptying    Other...  
 Unexplained discharge    Incontinence or leakage

### Endocrine (hormonal) system

- Tremors    Changes of appetite    Unexplained swellings    Other...  
 Excessive thirst    Unexplained weight loss    Tiredness or lethargy  
 Excessive need to urinate    Unexplained weight gain    Excessive perspiration

### Nervous system

- Dizziness or difficulty with balance    Migraines    Changes in hearing or tinnitus    Numbness  
 Headaches    Visual disturbances    Tingling or altered sensations    Other...

### Gastro-intestinal system

- Difficulty swallowing    Ulcer    Frequent diarrhea    Bloating  
 Indigestion, heart-burn or reflux    Change in bowel habits    Frequent constipation    Other...  
 Gall-bladder problems    Intestinal pain    Nausea

### Immune system

- Hayfever    Psoriasis    SLE    Anaphylactic reactions    Other auto-immune disease  
 Asthma    Rheumatoid arthritis    Crohn's disease    Other allergies    Other...

### Psychological

- Depression    Anxiety    General irritability    Feeling stressed    Other...

### Sleep health

- Trouble getting started in the morning    Trouble getting to sleep at night  
 Over-tired during the day    Trouble staying asleep in the early morning  
 Over-tired in the evening    Other...

## How is your energy level?

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## Have you had manual therapy (e.g. osteopathy, chiropractic, physiotherapy, massage, Bowen therapy) before, and, if so, was there any aspect of your treatment that you particularly liked or disliked?

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## Is there anything else important in your medical history?

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# Medical History

What are your health goals?

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**Please draw your pain on this diagram. You can use some of these symbols if you find it helpful; otherwise just scribble:**

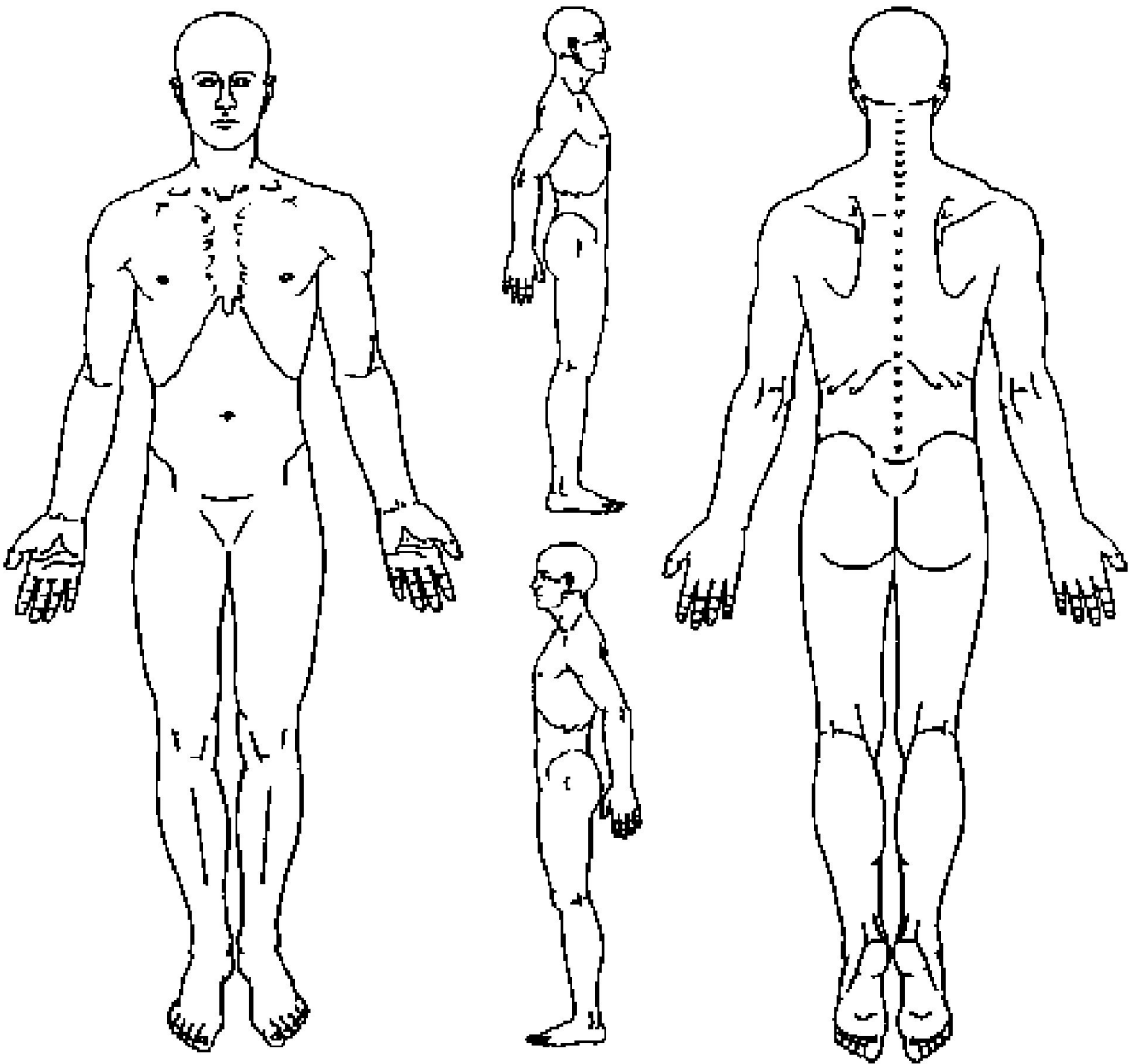
X = general pain

O = stiffness

| = numbness, tingling, cold ache or something else that feels like nerve pain

^ = sharp stabbing

? = something hard to describe



How long have you had your pain? ..... years ..... months ..... days