



ROYAL MEDICAL GROUP, PLLC
"Personalized Care for Optimal Health"

PATIENT HISTORY

Patient: _____ Date: _____
First Middle Initial Last

Street Address: _____

City: _____ State: _____ Zip: _____

Phone(s): Home: _____ Cell: _____ Office: _____

Email(s): _____

Chief Complaint(s): _____

Medications: _____

Surgical History: _____

Health History

- | | | | |
|--------------------------------------|--|---|--|
| Are you tired or easily fatigued? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Have you lived with someone who has TB? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you have trouble sleeping? | Yes <input type="checkbox"/> No <input type="checkbox"/> | (Men) Do you have impotence? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you get up at night to urinate? | Yes <input type="checkbox"/> No <input type="checkbox"/> | (Men) Do you have an elevated PSA? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you had a cough for >3 weeks? | Yes <input type="checkbox"/> No <input type="checkbox"/> | (Women) Do you have Irregular periods? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If so, is blood in sputum? | Yes <input type="checkbox"/> No <input type="checkbox"/> | (Women) Do you have heavy bleeding? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you have unexplained weight loss? | Yes <input type="checkbox"/> No <input type="checkbox"/> | (Women) Do you have menstrual cramps? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Are you having night sweats? | Yes <input type="checkbox"/> No <input type="checkbox"/> | (Women) Do you have PMS? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Have you recently been outside U.S.? | Yes <input type="checkbox"/> No <input type="checkbox"/> | | |

Lifestyle Habits

- | | | | |
|-----------------------------------|--|-----------------------|--|
| Do you drink Coffee or Black Tea? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Do you drink Alcohol? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you drink Soda Pop? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Do you use Tobacco? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Digestive Function

- | | | | |
|----------------------------------|--|-----------------------------|--|
| Do you have food intolerances? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Do you have blood in stool? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you have reflux or heartburn? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Do you have constipation? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Do you have bloating or gas? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Do you have diarrhea? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Other Conditions

(Check those that apply to you now)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Allergies (Inhalants) | <input type="checkbox"/> Colitis | <input type="checkbox"/> Fatigue, Chronic | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Allergies (foods) | <input type="checkbox"/> Constipation | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Gastritis | <input type="checkbox"/> Irritable Bowel |
| <input type="checkbox"/> Angina (Chest Pains) | <input type="checkbox"/> Cough | <input type="checkbox"/> Gastroenteritis | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis, Osteo | <input type="checkbox"/> Diabetes I (Non-Insulin) | <input type="checkbox"/> Headache | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Asthma, Chronic | <input type="checkbox"/> Diabetes II (Insulin) | <input type="checkbox"/> Headache, Migraine | <input type="checkbox"/> Rhinitis |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Bronchitis, Chronic | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Candida Albicans | <input type="checkbox"/> Ear Infection | <input type="checkbox"/> Herpes | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Cardiac Arrhythmia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hives | <input type="checkbox"/> Ulcerative Colitis |