JOINT AND MUSCLE RESEARCH INSTITUTE
Medical History Form

Name: ______________________________ Date of Birth: ___________

CHECK YES OR NO FOR ANYTHING DIAGNOSED, TREATED FOR, OR RECURRING PROBLEM WITH:	YES	NO	ONSET DATE	STOP DATE	CHECK IF CONT	COMMENT
ALLERGIC REACTIONS:						
Food Allergies					☐	
Drug Allergies					☐	
Hypersensitivity					☐	
Infusion Related Reaction					☐	
GENERAL						
Fatigue					☐	
Fever					☐	
Cancer					☐	
Other:___________						
Other:___________						
EARS, NOSE, THROAT						
Presbyacusis					☐	
Hoarseness					☐	
Productive cough					☐	
Sinus problems					☐	
Nose bleed					☐	
Ringing in ears					☐	
Other:___________						
Other:___________						
OPHTHALMIC						
Glaucoma					☐	
Cataracts					☐	
Double vision					☐	
Dry Eyes					☐	
Other:___________						
Other:___________						
RESPIRATORY						
Allergic Rhinitis(seasonal/ year round)					☐	
Asthma					☐	
Pneumonia					☐	
Bronchitis					☐	
COPD					☐	
Emphysema					☐	
Shortness of Breath					☐	
Sleep Apnea					☐	
Positive TB test					☐	
Other:___________						

 Disease Type ____________________ Date of Diagnosis: _______________

CHECK YES OR NO FOR ANYTHING DIAGNOSED, TREATED FOR, OR RECURRING PROBLEM WITH:	YES	NO	ONSET DATE	STOP DATE	CHECK IF CONT	COMMENT
Other:___________						
CARDIOVASCULAR						
Heart Murmur, Irregular Heartbeat					☐	
Angina Pectoris					☐	
Myocardial Infarction					☐	
Stroke					☐	
Hypertension					☐	
Hyperlipidemia					☐	
Thromboembolic event					☐	
Congestive Heart failure					☐	
Hypercholesterolemia					☐	
Edema (arms, hands, legs and feet)					☐	
Systemic/Pulmonary Emoblism					☐	
Tachycardia/Bradycardia					☐	
GASTROINTESTINAL/ LIVER						
Stomach Ulcers					☐	
Gallstones/Gallbladder problems					☐	
Heartburn/ GERD					☐	
Diarrhea					☐	
Constipation					☐	
Irritable Bowel Syndrome					☐	
Crohn's Disease					☐	
Diverticulitis/Diverticulosis					☐	
Hepatitis					☐	
Abnormal Liver Funtion					☐	
Celiac Disease					☐	
Abdominal pain					☐	
Nausea						
Vomiting					☐	
Jaundice					☐	
Other:___________						
Other:___________						
RENAL						
Kidney Stones					☐	
Urinary Tract Infection					☐	
Difficulty/painful/frequent Urination					☐	
Nephritis						
Renal Failure					☐	
Other:___________					☐	
Other:___________						
NEUROLOGIC						
Epilepsy					☐	

 Pt Initials: ___________

CHECK YES OR NO FOR ANYTHING DIAGNOSED, TREATED FOR, OR RECURRING PROBLEM WITH:	YES	NO	ONSET DATE	STOP DATE	CHECK IF CONT	COMMENT
Migraines/Headaches					☐	
Dizziness/Vertigo					☐	
Loss of balance					☐	
Chronic numbness					☐	
Tremors					☐	
Loss of consciousness					☐	
Arm/leg weakness					☐	
Seizures					☐	
Speech Difficulty					☐	
Other:___________						
MUSCULOSKELETAL						
Arthritis					☐	Specify:
Chronic Neck					☐	
Back Pain					☐	
Muscle Ache					☐	
Joint pain					☐	
Osteoporosis					☐	
Gout					☐	
Fibromyalgia					☐	
Tendonitis					☐	
Bursitis					☐	
ENDOCRINE						
Hyperthyroidism					☐	
Hypothyroidism					☐	
Diabetes Type I					☐	
Diabetes Type II					☐	
Pancreatitis					☐	
LYMPH/BLOOD						
Low platelets					☐	
Anemia					☐	
Tender lymph node					☐	
Blood transfusion					☐	
PSYCHIATRIC						
Depression					☐	
Anxiety					☐	
Traumatic event					☐	
Paranoia					☐	
Suicidal ideation					☐	
Suicidal depression					☐	
Suicidal behavior					☐	
Attempted suicide					☐	
Insomnia					☐	
Bipolar Disorder					☐	
Drug/Alcohol Abuse					☐	
Dementia/Alzheimer’s					☐	
SERIOUS INFECTION						
Cellulitis					☐	
Fungal Infection					☐	
Herpes Virus Infection					☐	
HIV					☐	
Sepsis					☐	

 Pt Initials: ___________

CHECK YES OR NO FOR ANYTHING DIAGNOSED, TREATED FOR, OR RECURRING PROBLEM WITH:	YES	NO	ONSET DATE	STOP DATE	CHECK IF CONT	COMMENT
Opportunistic Infection					☐	Specify:
SKIN						
Dermatitis					☐	
Rosacea					☐	
Psoriasis					☐	
Rash and hives					☐	
Scalp tenderness					☐	
Alopecia					☐	
FOR WOMEN ONLY						
Hysterectomy					☐	
Post menopausal nature					☐	
Irregular menstruation					☐	
Breast lump					☐	
If of child bearing potential:					☐	Form of contraception:
Date of last Menstrual period: _____/______/________					☐	
Pregnancies: Full Term: ______ Pre Term: ______ Miscarriage: ______ Abortion: _______						
FOR MEN ONLY						
Impotence					☐	
Prostate enlargement/disorder					☐	
OTHER						
Alcohol Use: ☐ Present ☐Past					☐	If yes: Average weekly consumption: ___________________________
Tobacco Use: ☐ Present ☐Past ☐Cigarettes ☐Cigars ☐Chewing Tobacco					☐	# used:_____ per day/week # of years:______
SURGICAL PROCEDURES:						
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						

SUBJECT SIGNATURE: ______________________________ DATE: ____/____/_____

REVIEWED BY COORDINATOR: ______________________DATE: ____/____/_____

REVIEWED BY PI: ____________________________________DATE: ____/____/____