Medical and. Health History

A. Identification

Name:_____ Age:_____ Birthdate:__/__/___ Sex M/F

Address:_____ City:_____ State:_____ Zip:_____

Phone (H):_____ (W):_____ Occupation:_____

Email:_____ Fax: _____

Social Security # _____ How did you hear of us? _____

Family Status : Single / Divorced / Married / Widow(er)/ Significant other (circle one)

Emergency contact_____ Phone #_____

B. Insurance Information

Insurance Company:_____ Policy#:_____ Group name:_____

Insured's name (holder of policy):_____ Insured's SS# _____

I authorize the release of medical information necessary to process this and related claims. I request payment to myself or to the party who provided the care.

Signature_____ Date_____

C. Chief Complaint

PLEASE LIST YOUR MAJOR PROBLEMS AND/OR SYMPTOMS AND THE APPOXIMATE DATE IT BEGAN (If none please write your reason for seeking this consultation) PLEASE RANK IN ORDER OF IMPORTANCE TO YOU.

	when problem began
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

What are your expectations regarding what you would like our office to provide for you?

_____

_____

_____

If you have you seen other practitioners for these problems, indicate the results of these evaluations:

_____

_____

_____ _____

D. Your Past Medical History

Please indicate if you have had any of the following problems in the past. Please note years affected.

Alcoholism _____
Allergies _____
Anemia _____
Arthritis _____
Asthma _____
Bleeding / Bruising _____
Cancer _____
Crohn's Disease / Colitis _____
Depression _____
Diabetes _____
Digestive Disease _____
Drug Problems _____
Eating Disorder _____
Heart Disease _____
Herpes _____
HIV _____
Hypoglycemia _____
Hepatitis _____
High Cholesterol _____
High Blood Pressure _____
Irritable Bowel _____
Kidney Disease _____
Lupus _____
Lyme Disease _____
Mental Illness _____
Migraine Headache _____
Multiple Sclerosis _____
Pneumonia _____
Polio _____
Rheumatic Fever _____
Stroke / TIA _____
Seizures _____
Stomach / Intestinal Ulcers _____
Tuberculosis _____
Thyroid Disease _____
Venereal Disease _____

_____
_____
_____

Do you have a primary care provider?

Yes [ ] No [ ]

If Yes, please complete provider's information:
Name: _____
Address: _____
_____
Phone: _____

Your Tests: specify when if known

Last Physical Exam: _____
Chest-X-ray: _____
EKG: _____
Blood tests: _____
Urine tests: _____
Rectal Exam: _____
PAP smear _____
Breast exam: _____

Immunizations: specify when if known

Smallpox _____
Polio _____
Measles/mumps/rubella _____
Pertussis _____
Diptheria _____
Tetanus _____
Influenza _____
Hepatitis B _____
Chicken pox _____
Other

Hospitalization and Surgeries (dates / type)

_____
_____
_____
_____
_____
_____

E. Family History

For each family member write age or if deceased – age at death and any medical problems they have or had.

Mother_____
Grandmother_____
Grandfather_____
Father_____
Grandmother_____
Grandfather_____
Siblings:

_____
_____
_____
_____
_____

Children:

_____
_____
_____
_____
_____

F. Current Medications

Please write name, dosage and how often taken.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____

Please list any medications you may have an allergy to and the type of reaction.

_____
_____
_____

G. Lifestyle and Habits

Tobacco:

Do you currently smoke?_____
Do you currently chew?_____

If yes:
How much per day?_____
For how long?_____
If no:
Did you ever smoke?_____
For how long?_____
When did you stop?_____

Alcohol
(Includes wine, beer and liquor)
How often do you drink:
[ ] Never
[ ] Less than 1 time per week
[ ] 2 – 5 times per week
[ ] At least once daily
What do you drink?_____
Was drinking ever a problem?_____

Caffeine

How many cups of the following do you consume daily

Coffee_____
Black Tea_____
Green Tea_____
Cola_____
Diet Cola_____
Chocolate_____

Recreational Drug Use
(type/frequency)_____
_____

Over the Counter Medications
(type/frequency)_____
_____
_____
_____
_____
_____

NAME_____

SYMPTOM AND SYSTEM REVIEW: Write **all** the appropriate letters in the left hand columns. **DO NOT fill anything** if the problem does not apply to you.

Write **"C"** for a **current** problem **"I"** if it is an **intermittent** problem **"P"** for a **past** problem

_____headaches
_____neck lumps or swelling
_____loss of balance
_____dizzy spells
_____vertigo
_____blackouts or fainting
_____blurry vision
_____double vision
_____cataracts
_____eye pain or itching
_____watering eyes or redness
_____hearing difficulties
_____earaches or drainage
_____noises or ringing in ears
_____recurrent ear infections
_____dental problems / decay
_____sore or bleeding gums
_____sore tongue
_____coated tongue
_____loss of taste or smell
_____sores in or around mouth

_____difficulty swallowing
_____cold sores or fever blisters
_____sinus or nasal congestion
_____runny nose
_____frequent colds
_____nasal polyps
_____sore throats
_____swollen glands
_____recurrent fevers or chills
_____hoarse voice
_____shortness of breath
_____wheezing or gasping
_____coughing
_____coughing blood
_____chest colds or pneumonia
_____heart murmur

_____high blood pressure
_____skipped heartbeats
_____racing heart
_____chest pain or pressure
_____swollen feet or ankles
_____difficulty breathing at night
_____varicose veins or phlebitis
_____recurring indigestion
_____nausia or vomiting
_____intestinal gas / flatulence
_____belching
_____bloating
_____abdominal pain or cramps
_____constipation
_____diarrhea or loose stools
_____rectal itching
_____flood with stools
_____black stools
_____pain in rectum
_____jaundice
_____hepatitis / pancreatitis
_____colitis
_____Crohn's disease
_____diverticulitis / diverticulosis

_____frequent urination
_____brown or red urine
_____decreased force of urine
_____continual urge to urinate
_____involuntary escape of urine
_____difficulty starting urination
_____kidney or bladder infection
_____venereal disease
_____osteoporosis
_____aching muscles or joints
_____arthritis
_____joint stiffness
_____back or neck pain

_____weakness
_____painful feet
_____leg cramps
_____trembling or tremors
_____seizures or epilepsy
_____numbness or tingling
_____skin tumors
_____dry skin
_____acne
_____eczema
_____skin rashes
_____psoriasis
_____dandruff or seborrhea
_____hives
_____itching or burning skin
_____easy bruising
_____hypothyroid (low)
_____hyperthyroid (high)
_____weight gain
_____weight loss
_____feel excessively warm
_____feel excessively cold
_____loss of appetite
_____constant hunger
_____fatigue or weariness
_____night sweats
_____diabetes
_____low blood sugar
_____nervousness or anxiety
_____depression
_____suicidal thoughts
_____sought psychological help

MEN ONLY
_____painful testicles
_____hernia
_____prostate problems
_____sexual dysfunction

LIFE CHANGE INDEX

This index, developed by Drs. Holmes and Rahe, indicates degrees of stress related to changes in life. Even enjoyable events can be stressful. Life change scores that are high are related to more illness. In studies, many people who scored over 300 became ill within a three to six month period.
If an event has been true for you in the past year, or is about to happen, circle the associated point value. If an unlisted event has occurred, add it to the bottom of the list and assign it a point value. Add up the points.

Death of spouse or partner	100
Divorce	73
Separation from spouse or partner	65
Jail term	63
Death of close family member	63
Personal injury or illness	53
Marriage/commitment to a partner	50
Fired at work	47
Reconciliation with spouse/partner	45
Retirement	45
Change in health of family member	44
Pregnancy	40
Sex difficulties	39
Addition of new family member	39
Business readjustment	39
Change in financial state	38
Death of a close friend	37
Change to a different line of work	36
More arguments with spouse/partner	35
Mortgage over $50,000	31
Foreclosure of mortgage or loan	30
Change in work responsibilities	29
Child leaving home	29
Trouble with in-laws	29
Outstanding personal achievement	28
Spouse/partner begins/stops work	26
Begin or end school	26
Change in living conditions	25
Revision of personal habits	24
Trouble with boss or employee	23
Change in work hours or conditions	20
Change in residence	20
Change in schools	20
Change in recreation	19
Change in church activities	19
Change in social activities	18
Mortgage or loan under $50,000	17
Change in sleeping habits	16
Change in eating habits	15
Vacation	13
Christmas approaching	12
Minor violations of the law	11
Other	___

TOTAL **ALL THE POINTS** _____

NUTRIENT SUPPLEMENTS

If you are taking vitamins, minerals or other supplements, please list them below. Be sure to indicate the dose in milligrams or units, the brand, and the number of pills taken per day. Try to bring the label of any multiple or combination formulas. Use a separate sheet if necessary.

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DIET SURVEY NAME___________________________________

Please check all the following statement, being careful to use the appropriate box related to the frequency of your personal habits.

"FREQUENT" = at least once per day; "OFTEN" = several time per week; "OCCASIONAL" = once a week or less; "SELDOM" = once or twoic per month or less; "NEVER" = almost total avoidance

Frequent	Often	Occasional	Seldom	Never	
					1. alcoholic beverages
					2. eat at restaurants
					3. eat at fast food restaurants
					4. pastries, cookies, candies, ice cream, other sweets
					5. add sugar to coffee, tea, cereals or other foods
					6. colas or other soft drinks
					7. instant breakfasts, pop tarts, doughnuts, muffins
					8. cold breakfast cereals
					9. caffeine drinks (coffee, tea, cola, chocolate)
					10. deep fried foods
					11. margarine of any type
					12. whole grain hot cereals (oatmeal, wheatena, etc)
					13. meat (beef or veal, pork or ham, lamb, liver)
					14. chicken or turkey--circle: regular or free range
					15. fresh fish
					16. processed meat (bologna, turkey roll, sausage, etc.)
					17. fresh raw fruit
					18. fresh vegetables, raw or cooked
					19. salads
					20. whole grains or whole grain breads
					21. white bread or white flour products
					22. beans and legumes (lentil, kidney, chickpea, etc.)
					23. yogurt-circle: whole or lowfat, plain or flavored
					24. milk-circle: whole, lowfat or skimmed
					25. cheese
					26. eggs-circle: regular or free range
					27. salt
					28. herbs, fresh and dried, or spices
					29. drink adequate water-circle: tap, filtered, bottled
					30. eat excessively if bored or depressed
					31. swallow food before chewing well
					32. hurried or rushed meals
					33. stuff yourself
					34. read and understand food labels
					35. sneak or hide foods
					36. adequate fibber or roughage in the diet
					37. artificial sweeteners (saccharin, Nutrasweet, etc.)
					38. shop at health food stores