HEALTH HISTORY

WE TAKE YOUR MEDICAL HISTORY SERIOUSLY AND NEED YOU TO BE AS COMPLETE AND ACCURATE AS POSSIBLE. PLEASZE COMPLETE THE FOLLOWING FOR YOUR INITIAL EVALUATION.

NAME:___________________________ HEIGHT:______ APPROX. WEIGHT________

REASON FOR CONSULTATION:

____

PAST SURGERIES **DATE/YEAR** **COMPLICATIONS**

____

____

____

CURRENT MEDICATION **DOSE/FREQUENCY**

____

____

____

HERBAL MEDICINE/SUPPLEMENT(S)

____

ALLERGIES TO MEDICATIONS **REACTIONS**

____

____

____

ARE YOU ALLERGIC TO LATEX? __YES __NO

FAMILY HISTORY **AGE** **HEALTH CONCERNS/CAUSES OF DEATH**

FATHER:____

MOTHER:____

__BROTHER(S): ____

__SISTER(S):____

ANY FAMILY HISTORY OF: __BREAST CANCER __COLON CANCER __LUNG CANCER __PROSTATE CANCER __UTERINE/OVARIAN CANCER __HEART ATTACK/DISEASE (UNDER 60) __SUDDEN CARDIAC DEATH

SOCIAL HISTORY (CHECK ALL THAT APPLY):

__SINGLE __MARRIED __SEPARATED __DIVORCED __WIDOW OCCUPATION:__________________

CHILDREN:

SON(S) _____ AGES:_______________ HEALTH:______________________________

DAUGHTER(S) _____ AGES:_______________ HEALTH:___________________________

DO YOU:

DRINK ALCOHOL? __N __Y HOW OFTEN/AMOUNT?_____________________

USE TOBACCO? __N __Y AMOUNT PER DAY, CIGARETTES_________________ CIGARS_________________

SNUFF/CHEW____________ PIPE______________ IF QUIT, WHEN?_________________________

HAVE YOU EVER BEEN ADDICTED TO DRUGS/ALCOHOL? __N __Y

ARE YOU CURRENTLY USING RECREATIONAL DRUGS? __N __Y TYPE?_______________________

PREVIOUS BLOOD TRANSFUSIONS __N __Y WHEN?_________________________________

KNOWN EXPOSURE TO HIV/AIDS __N __Y

PAST MEDICAL HISTORY: __HIGH BLOOD PRESSURE __HEART ATTACK __STROKE

__HEART DISEASE __HIGH CHOLESTEROL __SEIZURE __ASTHMA/COPD

__LUNG DISEASE __STOMACH ULCERS __COLON POLYPS __KIDNEY DISEASE

__SLEEP APNEA __BLOOD CLOTS IN LEGS __BLOOD CLOTS IN LUNGS __ARTHRITIS

__THYROID DISEASE __PSYCHIATRIC DISORDER __DIABETES: INSULIN? __Y __N

__OTHER:____

____

DO/HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY:

CONSTITUTIONAL: __Fatigue __Fever __Chills/Shaking Chills __Weight Loss __Loss of Appetite __Night Sweats

HEENT: __Morning Headaches __Migraines __Blurred/Double Vision __Transient Vision Loss __Ear Ache __Hearing Loss __Ringing in Ears __Nosebleeds __Sinus Infections __Sore Throat __Goiter __Difficulty/Painful Swallowing

CARDIOVASCULAR: __Chest Pain/Tightness __ Heart Murmur/Palpitations __Ankle Swelling __Leg Cramps (Walking) __Nighttime Leg Cramps __Blackouts/ Fainting __Varicose Veins

PULMONARY: __Shortness Of Breath __Cough __Colored/Bloody Sputum __Asthma __TB __COPD __Emphysema

GI/GU: __Heartburn/Indigestion __Nausea/Vomiting __Reflux __Abdominal Pain __Wheezing __Abdominal Bloating __Black Stools __Bloody Stools __Constipation __Diarrhea __Change in Bowel Habits __Increased Urination __Burning Urination __Bloody Urination __Kidney Stones __Loss of Bladder Control __Difficulty With Erections __Unusual Vaginal Discharge __Painful Intercourse

SKIN: __Skin Abscess __Easily Bruises/Bleeds __Tattoos __ Rashes __History of Shingles __Skin Conditions __Skinfold Irritation

MUSCULOSKELETAL: __Neck Pain __Low Back Pain __Joint Pain __Knee Pain __Hip Pain __Foot Ulcers

ENDOCRINE: __Heat or Cold Intolerance __Excessive Thirst or Appetite __Excessive Urination

NEUROLOGIC: __Dizziness __Numbness/Tingling __Falling Down __Trouble Walking __Weakness/Paralysis __Seizures

HEMATOLOGICAL/LYMPH: __Swollen Glands __Anemia __Bleeding Disorders __Clotting __Cancer: Type____________________

SLEEP: __Snoring __Insomnia __Waking Gasping __Observed Apnea __Restless Legs __Shift Work __Unable to Remain Awake __Sleep Apnea

PHYCHIATRIC: __Anxiety __Depression __Mood Disorder __Other________________________

MISC: __USE OXYGEN AT HOME: LPM____ __USE WHEELCHAIR AT HOME? WHY? _______________

ALLERGY/IMMUNOLOGY: __SEASONAL WHAT?___________________ __FOOD WHAT?___________

THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

____

PATIENT SIGNATURE DATE

I personally reviewed all the above information with the patient during the exam and except for the symptoms marked, all others are negative.

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PHYSICIAN DATE