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Patient Health History

Name: _____ Date: _____
First Middle Last

Street Address: _____

City: _____ State: _____ Zip Code: _____

How did you hear about my practice?

Friend _____ Family Member _____

Web Site (if so, please list site) _____ Other _____

Successful healthcare and preventative medicine are only possible when I have a complete understanding of your physical, mental, emotional, and social situation. Please complete this questionnaire as thoroughly as possible to help me develop such an understanding. Please print or write legibly and mark any areas of confusion with a question mark (?). Thank you.

1. Are you currently receiving healthcare? **N** **Y** If yes, where and from whom _____

_____

If no, when was the last time you did? _____ What was the reason? _____

2. Has your case been referred to an attorney or are you planning to refer it to an attorney? **N** **Y**

3. Please identify the health concerns that have brought you to my clinic:
Condition **Past Treatment**

a. _____

How does this condition affect you? _____

b. _____

How does this condition affect you? _____

c. _____

How does this condition affect you? _____

d. _____

How does this condition affect you? _____

4. What are the most important health problems/concerns? Please list in order of importance.

a. _____ c. _____

b. _____ d. _____

5. Do you have any reason to believe that you are pregnant? **N** **Y**
If you are pregnant, approximately how far along is your pregnancy? _____

6. Do you have any chronic infections or infectious diseases? **N** **Y** If yes, please explain: _____

_____

7. Are you currently suffering from any chronic illnesses? **N** **Y**

8. If applicable, please list any foods, drugs, or medications to which you are hypersensitive or allergic (please include the type of reaction): _____

9. Please circle any of the following **medications** that you are currently taking:

Laxatives Pain Relievers Antacids Thyroid Medication Appetite Suppressants
Antibiotics Antidepressants Tranquilizers/Sleeping Pills Blood pressure Medication

Other _____

10. Please list the name(s) of any of the above medications that you are currently taking: _____
_____

11. **Height**: _____ Current **Weight**: _____ Past Max. Weight/When: _____ Past Min. Weight/When:_____

12. What is your most recent **Blood Pressure** reading? _____/_____ When was this reading taken? _____

13. Please circle any **childhood illnesses** that you had:
Scarlet Fever Diptheria Mumps Rubella Measles German Measles Chicken Pox Other: _____

14. Please circle any **immunizations** you have had:

Polio Tetanus Measles/Mumps/Rubella Pertussis Diptheria

Other: _____

15. Please list any **surgeries** or **hospitalization**s:

a. Reason:_____ When: _____

b. Reason:_____ When: _____

c. Reason:_____ When: _____

d. Reason:_____ When: _____

16. Please list any **X-Rays/CAT Scans/MRI's/NMRI's/Special Studies**

a. Reason:_____ When: _____

b. Reason:_____ When: _____

c. Reason:_____ When: _____

d. Reason:_____ When: _____

17. **Family History**:

	Mother	Father	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (Exc, Good, Poor)	_____	_____	_____	_____	_____	_____
Age at death (if deceased)	_____	_____	_____	_____	_____	_____
Cause of Death	_____	_____	_____	_____	_____	_____

Check below, any conditions that members of your family have or have had...

Diabetes	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental/Emotional	_____	_____	_____	_____	_____	_____
Other (please list)	_____	_____	_____	_____	_____	_____

18. Please circle any of the following that you experience now and underline any you have experienced in the past:

Anxiety Depression Mood Swings Suicidal Thoughts/Feelings

Excessive Fears (phobias) Periods of Extreme Activity or Elevated Mood Unusual Thoughts or Feelings

19. Please circle any of the following that you experience now and underline any you have experienced in the past:

Fatigue Slow Wound Healing Frequent/Chronic Infections Chronic Fatigue Syndrome

20. **(Head, Eye, Ear, Nose, and Throat)** Please circle any of the following that you experience now and underline any you have experienced in the past:

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness

Impaired Hearing Ear Ringing Earaches Headaches Sinus Problems

Nose Bleeds Frequent Sore Throats Hay Fever Teeth Grinding Teeth Grinding/Jaw Problems

21. **(Respiratory)** Please circle any of the following that you experience now and underline any you have experienced in the past:

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema

Persistent Cough Pleurisy Asthma Tuberculosis

Shortness of Breath Other Respiratory Problems/Issues: _____

22. **(Cardiovascular**) Please circle any of the following that you experience now and underline any you have experienced in the past:

Heart Disease Chest Pain Swelling of Ankles High Blood Pressure Low Blood Pressure

Varicose Veins Palpitations/Fluttering Stroke Heart Murmur Rheumatic Fever

23. **(GI)** Please circle any of the following that you experience now and underline any you have experienced in the past:

Ulcers Changes in Appetite Nausea/Vomiting Epigastric Pain Passing Gas Heartburn

Belching Gall Bladder Disease/Stones Liver Disease Hepatitis B or C Hemorrhoids Abdominal Pain

Diarrhea Constipation Undigested food in Stool Mucous in Stool Blood in Stool

a. Do you have cravings for any particular foods or flavors? **N Y** If yes, please list: _____

_____

24. **(GU)** Please circle any of the following that you experience now and underline any you have experienced in the past:

Kidney Disease Painful Urination Frequent Urinary Tract Infections Frequent Urination

Kidney Stones Impaired Urination Frequent Urination at Night Difficulty Starting

Difficulty Stopping Dribbling Weak Stream Blood in Urine

25. **(Female Reproductive)** Please circle any of the following that you experience now and underline any you have experienced in the past:

Breast Lumps/Tenderness Nipple Discharge Irregular Cycles Heavy Flow Clotting PMS/PMDD

Bleeding Between Cycles Difficulty Conceiving Vaginal Discharge Menopausal/Perimenopausal Symptoms

26. **Menstrual/Birthing History**

1. Age at first menses: _____ 2. # of days of menses/flow 3. Length of cycle: _____

4. Birth Control Y N (method): _____ 5. # of pregnancies: _____ 6. # of Miscarriages: _____

7. # of Abortions: _____ 8. # of Live Births: _____ 9. # of Vaginal Deliveries: _____ 10. # of C-Sections: _____

27. (**Male Reproductive)** Please circle any of the following that you experience now and underline any you have experienced in the past:

Prostate Problems Testicular Pain/Swelling Penile Discharge Erectile Difficulties

Premature Ejaculation Delayed Ejaculation Other: _____

28. (**Musculoskeletal)** Please circle any of the following that you experience now and underline any you have experienced in the past:

Neck/Shoulder Pain Leg Pain Arm Pain Low Back Pain Upper Back Pain Mid-Back Pain

Muscle Spasms/Cramps (if so, where): _____ Joint Pain (if so, where): _____

29. **(Neuro)** Please circle any of the following that you experience now and underline any you have experienced in the past:

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

30. **(Endocrine)** Please circle any of the following that you experience now and underline any you have experienced in the past:

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Mellitus Night Sweats Feeling Hot or Cold

31. **(Skin)** Please circle any of the following that you experience now and underline any you have experienced in the past:

Dry Eczema Psoriasis Seborrhea Frequent Rashes Acne Bruises Other: _____

32. **(Lifestyle)**

a. Please indicate your typical food intake

Breakfast: _____

Lunch: _____

Dinner:__ _____

Snacks: _____

b. Daily Exercise: _____

c. Sleep Habits: _____

d. Education: _____

e. Occupation: _____ Nature of Work: _____ Hrs./wk: _____

Do you enjoy work **N Y** Why/why not: _____

f. Nicotine/Caffeine/Alcohol Use **N Y** Amount of each and frequency: _____

g. Consumption of water/day: _____ Preferred Temperature: Cold Cool Room Temp Warm Hot

h. Have you experienced any major traumas? **N Y** If yes, please explain to the extent that you are comfortable:

_____

_____

i. How do you spend your leisure time? _____

_____

Is there anything else you think it would be helpful for me to know or that you would like to tell me? _____

_____

_____

_____

Thank you very much for taking the time to openly complete this form