DATE: ____________________________

NAME: _____________________________________ AGE:_____ DATE OF BIRTH:__________

I. PAST MEDICAL HISTORY

A. Surgeries:

Tonsillectomy Date: _________ HysterectomyDate:________AppendectomyDate:___________

Cholecystectomy Date: ________Other surgeries and dates:____________________

Biopsies done: what kind and dates: ______________________________________

B. Medical Problems:

____

____

____

____

D. Present Medications (prescription and over-the-counter):

Name Dose #Taken daily Reason

____

____

____

____

____

Herbs and Supplements: ____

____

E. Allergies: ____ or ○ No known drug allergies

Medications: What reaction:

____

____

Other Substances, Foods, etc:

____

F. Immunizations: Check Childhood Shots Given:

DPT ______ Mumps ______ Measles ______ Rubella ______ Polio ____ Smallpox ______

Tetanus Booster Date: ______________

Pneumovax (pneumonia vaccine) Date: ______________

Influenza (date of last shot) Date: ______________

Hepatitis B (series of 3 shots) Date: ______________

Others: Date: ______________

II. FAMILY HISTORY

Mother: Age (if living) ________ Age (at death) _________ Cause of death _________

List any medical problems she has had:

____

Father: Age (if living) ________ Age (at death) _________ Cause of death _________

List any medical problems he has had:

____

Brother (s) Ages and any medical problems he/they have had:_________________________________

____

Sister (s) Ages and any medical problems she/they have had: ________________________________
____

Any other blood relatives with:

	Relationship		Relationship
Diabetes	___________________	High blood pressure	___________________
Heart attack	___________________	Breast cancer	___________________
Stroke	___________________	Colon cancer	___________________
Tuberculosis	___________________	High cholesterol	___________________
Alzheimer's	___________________	Melanoma (skin cancer)	___________________
Prostate cancer	___________________	Ovarian cancer	___________________

III. LIFESTYLE HISTORY

A. Marital Status:

Single ❑ Married ❑ Divorced ❑

Significant Other (male) ❑ Significant other (female) ❑

B. Have you ever been pregnant? Yes ❑ No ❑ N/A ❑

If yes, how many pregnancies? How many births / children?

C. smoker (currently) ❑ ex-smoker ❑ nonsmoker ❑ chewing tobacco ❑

If a smoker, number of packs (pipes, cigars) per day________________________________

How long have you smoked?______________ If ex-smoker, when did you quit? ___________

D. Alcohol intake:

What do you usually drink? _____________ how much?__________ how often? ___________

❑ Do not drink alcohol

E. Exercise:

Do you exercise regularly? ___________ What activity_____________________________________

How often?____________________ How long is each session? ________________________

F. Diet -Check any foods you **avoid** in your diet:

❑ salt ❑ sugar ❑ fats (oils) ❑ red meat ❑ eggs ❑ poultry ❑ wheat ❑ caffeine ❑ other

Do you eat meat and how many times per week? ____

Do you eat fresh vegetables and how many times per day? _________________________________

Do you eat fresh fruits and how many times per day? ____________________________________

Do you eat fast food and how many times per week? _____________________________________

Do you eat processed foods, how many times per day? ____________________________________

G. Usual number of meals per day: _______ Number of times per week you eat "fast foods" __________

H. Travel ; Have you recently traveled outside the U.S.? _________

Where did you go? ____

I. Work

Current Occupation: ____

Have you had any work related illnesses or injuries? ______________________________________

J. Stress: Is your stress level Low, Moderate, or High?

K. Happiness: Is your happiness level Low, Moderate, or High?

L. Do you quiet your mind daily(in meditation, yoga, prayer, other)? Yes No

M. Do you engage in activities that you enjoy or have a passion for? Yes No

How often do you do this daily, weekly, monthly ?

IV. REVIEW OF SYSTEMS

A. Presently or in the recent past, have you had any of the following symptoms:

( ) Recurrent headaches		( ) Weight loss # of pounds	
( ) Fever (unexplained)		( ) Chills	
( ) Generalized fatigue		( ) Generalized weakness	
( )Double vision		( ) Ringing in ears	
( ) Recurrent sinus infection		( ) Recurrent sore throats	
( ) Hoarseness		( ) Neck stiffness	
( ) Coughing up blood		( ) Chronic cough	
( ) Chest pressure or tightness on exertion		( ) Chest pressure of tightness at rest	
( ) Feeling dizzy or off-balance		( ) Pain in legs while walking	
( ) Change in appetite		( ) Abdominal burning pain	
( ) Nausea		( ) Diarrhea	
( ) Change in bowel habits		( ) Rectal bleeding	
( ) Painful urination		( ) Change in urinary habits	
( ) Breast Pain		( ) Weight gain # of pounds gained	
( ) Night Sweats		( ) Generalized body aches	
( ) Change in vision		( ) Change in hearing	
( ) Frequent nosebleeds		( ) Recurrent gum or tooth infections	
( ) Constant sinus drainage		( ) Trouble swallowing	
( ) Swollen glands		( ) Shortness of breath on exertion	
( ) Shortness of breath while laying down		( ) Coughing up phlegm in the morning	
( ) Feeling faint or almost passing out		( ) Swollen ankles or feet	
( ) Heartburn or indigestion		( ) Abdominal cramping pain	
( ) Vomiting		( ) Constipation	
( ) Blood in or on stool		( ) Frequent or urgent urination	
( ) Blood in urine		( ) Vaginal discharge or odor	
( ) Change in menstrual periods		( ) Change in sexual desire	
( ) Breast lump		( ) Nipple discharge	
( ) Testicular pain		( ) Skin rash	
( ) Easy bruising or bleeding		( ) Changes in hair	
( ) Trouble sleeping		( ) Depression	
( ) Muscle weakness or pain		( ) Tingling in hands or feet	
( ) Joint swelling		( ) Testicular swelling	
( ) Changes in skin or moles		( ) Lumps in neck, underarms or groin	
( ) Sensation of being too hot or too cold		( ) Nervousness, panic	
( ) Mood swings		( ) Numbness	
( ) Joint pains		( ) Seizures or convulsions	
( ) Head injury and loss of consciousness		( ) Memory loss	

List any other problems not mentioned above:

____

____

____

V. HEALTH MAINTENANCE

A. Date of last physical / annual exam____________________________

B. Date of last Pap smear ____________________________

C. Date of last Cholesterol level ____________________________

D. Date of last EKG ____________________________

E. Date of last Chest X-ray ____________________________

F. Date of last Prostate exam ____________________________

G. Date of last Complete blood tests ____________________________

H. Date of last Thyroid level ____________________________

I. Date of last Sigmoidoscopy or Colonoscopy ____________________________

J. Date of last Bone density test ____

K. Date of last mammogram ____

L. Do you use a seat belt in your car? ____________________

VI. Main reason for your visit to the office today

____

____