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PATIENT INFORMATION AND HEALTH HISTORY

Patient Name ______________________________________ Date of Birth ______________

Address ____

City _______________________ State ______________ Zip code ______________

Home phone___________________________ Cell phone ____________________________

Work phone ___________________________ Email _________________________________

Would you like to be added to my email list to receive updates and special offers? Yes No

How did you hear about me? ____

What is your preferred name? (Nickname, chosen name, etc.)

____

What is your birth sex? ____________________

What gender do you identify as? _______________________

What is your preferred pronoun? He She Other (please specify) ___________

Occupation ________________________________ Hours worked per week ___________

Marital Status: Single Married Partnership Divorced/Separated Widowed

With whom do you live? Spouse Partner Parents Roommates Children Alone

Emergency Contact ____

Relationship _________________________________ Phone__________________________

Basic Medical History and Personal Information

When did you last visit a doctor's office, medical clinic, or hospital? Please explain.
____
____

What is the main reason for your visit today? ___________________________________
____

Please list your top 3 health concerns.
1. ____
2. ____
3. ____

Are you aware of any allergies to food, drugs, or environmental allergens (cats, mold, dust, etc.)? If yes, please list and explain. ______________________________________
____

Please list all hospitalizations and surgeries, including dates and outcomes:
____
____
____

Do you take or use any of the following more than once a week?

Pain relievers (aspirin, ibuprofen)
Diet pills, appetite suppressants
Cortisone (cream or pills)
Thyroid medication
Sleeping pills
Antacids
Laxatives
Tranquilizers
Antibiotics

Please list any prescription medications, over-the-counter medications, vitamins, or supplements you are regularly taking:____
____
____

When during the day is your energy best? ____

Family Medical History

Is your mother still living? ____ If yes, her age: ____ If no, her age at time of death:_____
Cause of death: ____

Is your father still living? _____ If yes, his age: ____ If no, his age at time of death: ______
Cause of death: ____

Do you have a family history of any of the following?

Anemia	Diabetes	Hay fever/hives	Liver disease
Arthritis	Epilepsy	Heart disease	Mental illness
Asthma	Gall bladder disease	Heart murmur	Stroke
Cancer	Glaucoma	High blood pressure	Tuberculosis
Cataracts	Goiter	Kidney disease	

Review of Systems

Please circle one: **Y** for a condition you have now; **P** for a condition you have had in the past; **N** for a condition you have never had:

Skin

Rashes	Y	P	N
Eczema, hives	Y	P	N
Acne, boils	Y	P	N
Itching	Y	P	N
Color change	Y	P	N
Lumps	Y	P	N
Night sweats	Y	P	N

Head

Headache	Y	P	N
Head injury	Y	P	N
Migraines	Y	P	N

Eyes

Impaired vision	Y	P	N
Glasses/contacts	Y	P	N
Eye pain	Y	P	N
Tearing, dryness	Y	P	N
Double vision	Y	P	N
Glaucoma	Y	P	N
Cataracts	Y	P	N

Ears

Impaired hearing	Y	P	N
Ringing	Y	P	N
Earache	Y	P	N
Dizziness	Y	P	N

Nose and Sinuses

Frequent colds	Y	P	N
Nose bleeds	Y	P	N
Stuffiness	Y	P	N
Allergies	Y	P	N
Sinus Problems	Y	P	N

Mouth and Throat

Sore throat	Y	P	N
Sore tongue	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Dental cavities	Y	P	N

Neck

Swollen glands	Y	P	N
Lumps/Goiter	Y	P	N
Pain or stiffness	Y	P	N

Respiratory

Cough	Y	P	N
Sputum	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N

Chest

Asthma	Y	P	N
Bronchitis	Y	P	N
Pneumonia	Y	P	N
Emphysema	Y	P	N
Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N
Tuberculosis	Y	P	N

Cardiovascular

Heart disease	Y	P	N
High blood pressure	Y	P	N
Murmurs	Y	P	N
Rheumatic fever	Y	P	N
Chest pain	Y	P	N
Swollen ankles	Y	P	N
Palpitations	Y	P	N

Urinary

Pain on urination	Y	P	N
Increased frequency	Y	P	N
Frequency at night	Y	P	N
Kidney stones	Y	P	N
Inability to urinate	Y	P	N
Weak urine stream	Y	P	N

Gastrointestinal

How often do you have a bowel movement?_________________

Is this a change?	Y	P	N
Trouble swallowing	Y	P	N
Heartburn	Y	P	N
Change in thirst	Y	P	N
Change in appetite	Y	P	N
Nausea/vomiting	Y	P	N
Vomiting blood	Y	P	N
Gas/bloating/belching	Y	P	N
Liver disease	Y	P	N
Gall bladder disease	Y	P	N
Ulcer	Y	P	N
Hemorrhoids	Y	P	N

Blood

Anemia	Y	P	N
Easy bleeding/bruising	Y	P	N

Peripheral vascular

Deep leg pain	Y	P	N
Cold hands/feet	Y	P	N
Varicose veins	Y	P	N

Neurological

Fainting	Y	P	N
Seizures	Y	P	N
Muscle weakness	Y	P	N
Numbness/Tingling	Y	P	N
Loss of memory	Y	P	N

Emotional

Depression	Y	P	N
Mood swings	Y	P	N
Anxiety	Y	P	N
Tension	Y	P	N

Social

Use rec. drugs	Y	P	N
Use alcohol	Y	P	N

Drinks per week: _____________

Use tobacco	Y	P	N

In what quantity: _____________

Musculoskeletal

Joint pain/stiffness	Y	P	N
Arthritis	Y	P	N
Broken bones	Y	P	N
Muscle spasms	Y	P	N

Endocrine

Diabetes	Y	P	N
Hypothyroid	Y	P	N
Heat/cold intolerance	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N

Breast

Self exams	Y	P	N
Lumps	Y	P	N
Tenderness	Y	P	N
Nipple discharge	Y	P	N

Male reproductive

Hernias	Y	P	N
Testicular masses	Y	P	N
Sexually active	Y	P	N
Sexual difficulties	Y	P	N
Prostate disease	Y	P	N
Venereal disease	Y	P	N
Discharge	Y	P	N
Sores	Y	P	N

Sexual preference:

Heterosexual______

Bisexual______

Homosexual______

Female reproductive

Date of last menses: _______________

Days of bleeding ______________

Length of cycles __________________

Bleed between periods	Y	P	N
Irregular cycles	Y	P	N
Painful menses	Y	P	N
Excessive flow	Y	P	N
Pain with intercourse	Y	P	N
Birth control	Y	P	N

What type? ______________________

# of Pregnancies ________

# of Miscarriages ________

# of Abortions _________

Difficulty conceiving	Y	P	N
Menopausal symptoms	Y	P	N
Sexually active	Y	P	N
Sexual difficulties	Y	P	N
Venereal diseases	Y	P	N

Sexual preference:

Heterosexual ______

Bisexual ______

Homosexual ______

Is there anything else you would like me to know in order to serve you better?

____

____

____