|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Birthdate:** |  |
| **Gender**(Please circle one): | Female Male FTM MTF Other |
| **Address:** |  |
| **City:** |  | **State**: |  | **Zip Code**: |  |
| **Phone:** |  | **Cell:** |  |
| **Email:** |  |
| **Social Security #:** |  | **Occupation** |  |
| **Emergency Contact**: |  | **Phone:** |  |
|  | **Relationship** |  |
| **Emergency Contact:** |  | **Phone:** |  |
|  | **Relationship** |  |
| **Marital Status**(circle one): | Single Married Separated Divorced Partner Other |
| **Do you have kids?** If yes, how many? |  |
| **Reason for visit?** |  |
| **Primary Health Concerns** (in order of importance) |
| Are you interested in (circle all that apply):Conventional Medicine Diet/lifestyle counseling Botanicals/Herbs Nutritional supplements Acupuncture  |

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Care Physician |  | Date of last physical exam: |  |
| PERSONAL HEALTH HISTORY |
|  |
| Childhood illness: | 🞎 Measles 🞎 Mumps 🞎 Rubella 🞎 Chickenpox 🞎 Rheumatic Fever 🞎 Polio |
| Immunizations and dates: | Tetanus |  | Pneumonia |  |
| Hepatitis |  | Chickenpox |  |
| Influenza |  | MMR Measles, Mumps, Rubella |  |
| List any medical problems that other doctors have diagnosed (Heart disease, high blood pressure, past or current cancer diagnoses, thyroid disease, COPD, diabetes, etc). |
|  |
|  |
|  |
|  |
| Surgeries |
| Year | Reason | Hospital |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Other hospitalizations |
| Year | Reason | Hospital |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |
| Have you ever had a blood transfusion? |  | Yes |  | No |

|  |
| --- |
| FAMILY HEALTH HISTORY |
|  | Age | Significant Health Problems |  | Age | Significant Health Problems |
| Father |  |  | Children | MF |  |  |
| Mother |  |  | MF |  |  |
| Sibling | MF |  |  | MF |  |  |
| MF |  |  | MF |  |  |
| MF |  |  | GrandmotherMaternal |  |  |
| MF |  |  | GrandfatherMaternal |  |  |
| MF |  |  | GrandmotherPaternal |  |  |
| MF |  |  | GrandfatherPaternal |  |  |

|  |
| --- |
| List prescription and over-the-counter drugs, such as vitamins and inhalers (attach additional sheets if necessary) |
| Name the Drug | Dosing | Reason for taking |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |
| --- |
| Allergies to medications |
| Name the Drug | Reaction You Had |
|  |  |
|  |  |
|  |  |
| Other allergies (food, seasonal/pollen, mold, etc) |
| Name the allergen | Reaction You Had |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| Lifestyle |
| Exercise | What type? How long and how many times per week? |
| **Diet** | Do you have food restrictions? |  | Yes |  | No |
| Describe average meals:*Breakfast*:*Lunch*:*Dinner*:*Snacks*:*Beverages*: |
| Caffeine | None | Coffee | Tea | Cola |  |
| # of cups/cans per day?  |
| Alcohol | Do you drink alcohol? |  | Yes |  | No |
| If yes, what kind?  |
| How many drinks per week?  |
| Tobacco | Do you use tobacco? |  | Yes |  | No |
| Cigarettes – pks./day: | Chew - #/day:  | Pipe - #/day: | Cigars - #/day: |
| # of years: | Or year quit: |
| Drugs | Do you currently use recreational drugs? |  | Yes |  | No |
| Have you ever injected drugs with a needle? |  | Yes |  | No |
| Sex | Are you sexually active? |  | Yes |  | No |
| Sexual preference (circle one): Heterosexual Homosexual Bisexual |
| Contraceptive or barrier method used:  |
| Other | Do you live alone? |  | Yes |  | No |
| Do you have frequent falls? |  | Yes |  | No |

**REVIEW OF SYSTEMS**

|  |
| --- |
| **Key** |
| **Y:** currently experiencing |
| **P:** experienced in the past |
| **N:** never experienced |
|  |
| **GENERAL** |
| Night sweats | Y | P | N |
| Fever | Y | P | N |
| Chills | Y | P | N |
| Thirst | Y | P | N |
| Fatigue | Y | P | N |
|  |  |  |  |
| **HEAD** |
| Headaches | Y | P | N |
| Dizziness | Y | P | N |
| Head Injury | Y | P | N |
|  |  |  |  |
| **SKIN** |
| Rashes/Eczema | Y | P | N |
| Acne | Y | P | N |
| Itching | Y | P | N |
| Color change | Y | P | N |
| Lumps | Y | P | N |
|  |  |  |  |
| **EYES** |
| Vision loss | Y | P | N |
| Blurred vision | Y | P | N |
| Floaters | Y | P | N |
| Eye pain | Y | P | N |
| Tearing or dryness | Y | P | N |
| Double vision | Y | P | N |
| Glaucoma | Y | P | N |
| Cataracts | Y | P | N |
|  |  |  |  |
| **EARS** |
| Hearing loss | Y | P | N |
| Ringing | Y | P | N |
| Ear pain | Y | P | N |
|  |  |  |  |
| **NOSE/SINUSES** |
| Frequent colds | Y | P | N |
| Nose bleeds | Y | P | N |
| Congestion | Y | P | N |
| Hay fever | Y | P | N |
| Sinus problems | Y | P | N |
|  |  |  |  |
| **MOUTH/THROAT** |
| Sore throat | Y | P | N |
| Ulcers | Y | P | N |
| Dentures | Y | P | N |
| Tooth pain | Y | P | N |
| TMJ pain | Y | P | N |
| Difficulty swallowing | Y | P | N |
| **NECK** |
| Neck pain | Y | P | N |
| Swollen glands | Y | P | N |
| Goiter | Y | P | N |
|  |  |  |  |
| **RESPIRATORY** |
| Cough | Y | P | N |
| Sputum | Y | P | N |
| Spitting up blood | Y | P | N |
| Wheezing | Y | P | N |
| Asthma | Y | P | N |
| Bronchitis | Y | P | N |
| Pneumonia | Y | P | N |
| Pleurisy | Y | P | N |
| Emphysema | Y | P | N |
| Difficulty breathing | Y | P | N |
| Shortness of breath | Y | P | N |
| Pain with breathing | Y | P | N |
|  |  |  |  |
| **CARDIOVASCULAR** |
| Heart disease | Y | P | N |
| Angina | Y | P | N |
| High blood pressure | Y | P | N |
| Murmurs | Y | P | N |
| Chest pain | Y | P | N |
| Swelling in ankles | Y | P | N |
| Palpitations/ fluttering | Y | P | N |
|  |  |  |  |
| **GASTROINTESTINAL** |
| Heartburn | Y | P | N |
| Change in appetite | Y | P | N |
| Nausea | Y | P | N |
| Vomiting | Y | P | N |
| Vomiting blood | Y | P | N |
| Bowel Movements |  |  |  |
|  | How many |  |  |  |
|  | Is this a change |  |  |  |
| Blood in stool | Y | P | N |
| Belching or passing gas | Y | P | N |
| Jaundice (yellow skin) | Y | P | N |
| Liver disease | Y | P | N |
| Hemorrhoids | Y | P | N |
|  |  |  |  |
| **URINARY** |  |  |  |
| Pain with urination | Y | P | N |
| Increased frequency | Y | P | N |
| Urgency | Y | P | N |
| Frequency at night | Y | P | N |
| Incontinence | Y | P | N |
| Kidney stones | Y | P | N |
|  |
|  |
| **WOMEN’S HEALTH** |
| Age at first period |  |  |  |
| Average # days |  |  |  |
| Length of cycle |  |  |  |
| Bleeding between periods | Y | P | N |
| Painful periods | Y | P | N |
| Excessive flow | Y | P | N |
| # of pregnancies |  |  |  |
| # of live births |  |  |  |
| # of miscarriages |  |  |  |
| # of abortions |  |  |  |
| Difficulty conceiving | Y | P | N |
| Menopausal symptoms | Y | P | N |
| Pain with intercourse | Y | P | N |
| Abnormal discharge | Y | P | N |
| Breast tenderness | Y | P | N |
| Nipple discharge | Y | P | N |
|  |  |  |  |
| **MEN’S HEALTH** |
| Hernias | Y | P | N |
| Testicular mass | Y | P | N |
| Testicular pain | Y | P | N |
| Sexual difficulties | Y | P | N |
| Prostate disease | Y | P | N |
| Discharge or sores | Y | P | N |
|  |  |  |  |
| **MUSCULOSKELETAL** |
| Joint pain/stiffness | Y | P | N |
| Arthritis | Y | P | N |
| Broken bones | Y | P | N |
| Muscle spasms or cramps | Y | P | N |
| Weakness | Y | P | N |
|  |  |  |  |
| **PERIPHERAL VASCULAR** |
| Deep leg pain | Y | P | N |
| Cold hands/feet | Y | P | N |
| Varicose veins | Y | P | N |
| Thrombophlebitis | Y | P | N |
|  |  |  |  |
| **NEUROLOGICAL** |
| Fainting | Y | P | N |
| Seizures | Y | P | N |
| Paralysis | Y | P | N |
| Muscle weakness | Y | P | N |
| Numbness or tingling | Y | P | N |
| Loss of memory | Y | P | N |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**REVIEW OF SYSTEMS (*cont.)***

|  |
| --- |
| **ENDOCRINE** |
| Thyroid disease | Y | P | N |
| Heat or cold intolerance | Y | P | N |
| Excessive thirst | Y | P | N |
| Excessive hunger | Y | P | N |
| Hormone replacement therapy | Y | P | N |
|  |  |  |  |
| **BLOOD** |
| Easy bleeding or bruising | Y | P | N |
| Anemia | Y | P | N |
|  |  |  |  |
| **SLEEP** |  |  |  |
| Difficulty falling asleep | Y | P | N |
| Difficulty staying asleep | Y | P | N |
| Early awakening | Y | P | N |
| Excessive dreaming | Y | P | N |
| Restless leg | Y | P | N |
|  |  |  |  |
| **EMOTIONAL** |
| Depression | Y | P | N |
| Anxiety | Y | P | N |
| Mood swings | Y | P | N |
| Suicidal thoughts | Y | P | N |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |