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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 | | | | | | | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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). | | | | | | | | | | | | | | |
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| Surgeries | | | | | | | | | | | | | | |
| Year | Reason | | | | | | Hospital | | | | | | | |
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| Other hospitalizations | | | | | | | | | | | | | | |
| Year | Reason | | | | | | Hospital | | | | | | | |
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| Have you ever had a blood transfusion? | | | | | | | | | | |  | Yes |  | No |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| FAMILY HEALTH HISTORY | | | | | | | |
|  | Age | | Significant Health Problems |  | Age | | Significant Health Problems |
| Father |  | |  | Children | M F |  |  |
| Mother |  | |  | M F |  |  |
| Sibling | M F |  |  | M F |  |  |
| M F |  |  | M F |  |  |
| M F |  |  | Grandmother Maternal |  | |  |
| M F |  |  | Grandfather Maternal |  | |  |
| M F |  |  | Grandmother Paternal |  | |  |
| M F |  |  | Grandfather Paternal |  | |  |

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| --- | --- | --- |
| List prescription and over-the-counter drugs, such as vitamins and inhalers (attach additional sheets if necessary) | | |
| Name the Drug | Dosing | Reason for taking |
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| --- | --- |
| Allergies to medications | |
| Name the Drug | Reaction You Had |
|  |  |
|  |  |
|  |  |
| Other allergies (food, seasonal/pollen, mold, etc) | |
| Name the allergen | Reaction You Had |
|  |  |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 |
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**REVIEW OF SYSTEMS (*cont.)***

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| --- | --- | --- | --- |
| **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 |
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