

Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____ Sex: M F

Are you: Married Single Divorced Widowed Separated

How did you hear about our center? _____

When did you have your last health care visit? _____

What was the reason? _____

Please list, in order of importance, your health problems:

1. _____
2. _____
3. _____
4. _____
5. _____

Family History

Y = yes

N = no

P = past

Has any family member had the following:

If yes, please identify family member:

Anemia	Y	N	P	_____
Asthma	Y	N	P	_____
Cancer	Y	N	P	_____
Diabetes	Y	N	P	_____
Epilepsy	Y	N	P	_____
Glaucoma	Y	N	P	_____
Heart Disease	Y	N	P	_____
High Blood Pressure	Y	N	P	_____
Kidney Disease	Y	N	P	_____
Mental Illness	Y	N	P	_____
Pneumonia	Y	N	P	_____
Stroke	Y	N	P	_____
Tuberculosis	Y	N	P	_____
Venereal Disease	Y	N	P	_____

Were any of these a cause of death? If so, which family member and at what age? _____

Immunizations

Polio	Y	N	Diphtheria	Y	N	Rubella	Y	N
Measles/Mumps	Y	N	Pertussis	Y	N	Hepatitis B	Y	N
Pneumonia	Y	N	Small Pox	Y	N	Anthrax	Y	N
Tetanus	Y	N	Date of last tetanus shot: _____					

Childhood Illnesses

Scarlet Fever	Y	N	Diphtheria	Y	N	Rheumatic Fever	Y	N
Mumps	Y	N	Measles	Y	N	German Measles	Y	N

Allergies

What are you allergic to? _____

What foods? _____

Environmental Allergies? _____

Have you ever been hospitalized? Y N If yes, when and for what reason? _____

Have you had any surgeries? Y N If yes, when and for what reason? _____

Current Medications

Appetite Suppressants	Y	N	Laxatives	Y	N
Tobacco	Y	N	Antacids	Y	N
Pain Relievers	Y	N	Tranquilizers	Y	N
Birth Control Pills	Y	N	Sleeping Pills	Y	N
Thyroid	Y	N	Cortisone	Y	N

Please list any prescription medications, over-the-counter medicines, vitamins or other supplements you are currently taking: _____

Environmental

Have you often had to lower the regular dose of prescription, over-the-counter medication or herbal supplements because you were too sensitive to normal doses? Y N P

Do you avoid caffeine in the afternoon or all together because it can keep you up at night? Y N P

Have you ever experienced adverse reactions to medications? If so, what happened?

Do you smell odors when others can't? What kind of odors?

Do you have a sudden onset of symptoms (headaches, skin rashes, nausea, fatigue, shortness of breath, etc.) on exposure to chemicals, mold, dust, pollens, or other environmental allergens? What symptoms?

Please list all the chemicals that you have adverse reactions to:

Skin

Acne	Y	N	P	Boils	Y	N	P
Color Changes	Y	N	P	Eczema	Y	N	P
Hives	Y	N	P	Itching	Y	N	P
Rash	Y	N	P	Moles	Y	N	P
Lumps	Y	N	P	Scaling	Y	N	P

Head

Hair loss	Y	N	P	Headaches	Y	N	P
Head Injury	Y	N	P	Skull fracture	Y	N	P

Eyes

Eye Pain	Y	N	P	Cataracts	Y	N	P
Double vision	Y	N	P	Dryness	Y	N	P
Vision aids	Y	N	P	Glaucoma	Y	N	P
Impaired vision	Y	N	P	Tearing	Y	N	P

Ears

Discharge	Y	N	P	Earaches	Y	N	P
Dizziness	Y	N	P	Impaired hearing	Y	N	P
Ringling	Y	N	P	Trauma to ear	Y	N	P

Nose & Sinuses

Frequent Colds	Y	N	P	Hay fever	Y	N	P
Nose Bleeds	Y	N	P	Sinus pain	Y	N	P
Stiffness	Y	N	P	Persistent running	Y	N	P
Trauma	Y	N	P	Polyps	Y	N	P

Mouth & Throat

Bleeding gums	Y	N	P	Difficulty swallowing	Y	N	P
Cavities	Y	N	P	Frequent sore throat	Y	N	P
Hoarseness	Y	N	P	Sore tongue	Y	N	P
Ulcerations	Y	N	P	Difficulty speaking	Y	N	P

Neck

Goiter	Y	N	P	Lumps	Y	N	P
Pain or Stiffness	Y	N	P	Swollen Glands	Y	N	P
Trauma to Neck	Y	N	P	Thyroid Medication	Y	N	P

Respiratory

Asthma	Y	N	P	Bronchitis	Y	N	P
Cough	Y	N	P	Emphysema	Y	N	P
Pneumonia	Y	N	P	Difficulty Breathing	Y	N	P
Pleurisy	Y	N	P	Pain with Breathing	Y	N	P
Sputum	Y	N	P	Shortness of Breath	Y	N	P
Tuberculosis	Y	N	P	with lying down	Y	N	P
Wheezing	Y	N	P	with exertion	Y	N	P
Blood in Sputum	Y	N	P	at night	Y	N	P

Cardiovascular

Angina	Y	N	P	Chest Pain	Y	N	P
High blood pressure	Y	N	P	Dizziness	Y	N	P
Heart disease	Y	N	P	Murmur	Y	N	P
Palpitations/flutter	Y	N	P	Leg pain with walking	Y	N	P
Rheumatic fever	Y	N	P	Ankle swelling	Y	N	P

Gastrointestinal

Belching	Y	N	P	Blood in stool	Y	N	P
Change in appetite	Y	N	P	Change in thirst	Y	N	P
Gall bladder disease	Y	N	P	Heartburn	Y	N	P
Gas/Bloating	Y	N	P	Hemorrhoids	Y	N	P
Liver disease	Y	N	P	Jaundice/yellow skin	Y	N	P
Vomiting	Y	N	P	Bowel Movements:			
Ulcers	Y	N	P	How often? _____			
				Is this a change? Y N			

Urinary

Frequent infections	Y	N	P	Frequency at night	Y	N	P
Increased frequency	Y	N	P	Unable to hold urine	Y	N	P
Kidney stones	Y	N	P	Kidney Pain	Y	N	P
Pain with urination	Y	N	P	Urethral discharge	Y	N	P

Endocrine/Blood

Anemia	Y	N	P	Excessive thirst	Y	N	P
Easy to bleed/bruise	Y	N	P	Heat/cold intolerance	Y	N	P
Excessive hunger	Y	N	P	Low energy/fatigue	Y	N	P

Female Reproductive System

Age menses began: _____				Birth Control	Y	N	P
Average number of days: _____				what type? _____			
Length of cycle: _____				Number of pregnancies: _____			
Are cycles regular?	Y	N	P	Number of live births: _____			
<u>Do you have:</u>				Number of miscarriages: _____			
Painful menses	Y	N	P	Number of abortions: _____			
Pain with intercourse	Y	N	P	Difficulty conceiving	Y	N	P
Excessive flow	Y	N	P	Menopause symptoms	Y	N	P
PMS	Y	N	P	History of venereal disease	Y	N	P
Sexual difficulties	Y	N	P	Are you sexually active	Y	N	P

Breasts

Do you do self exams	Y	N	P	Nipple discharge	Y	N	P
Lumps	Y	N	P	Skin discoloration	Y	N	P
Breast Pain	Y	N	P				

Male Reproductive System

Hernia	Y	N	P	Are you sexually active	Y	N	P
Testicular pain	Y	N	P	Sexual difficulties	Y	N	P
Testicular masses	Y	N	P	Prostate disease/pain	Y	N	P
Discharges or sores	Y	N	P	Venereal disease	Y	N	P

Musculoskeletal

Joint pain/stiffness	Y	N	P	Broken bones	Y	N	P
Swelling of joints	Y	N	P	Muscle cramps	Y	N	P
Arthritis	Y	N	P	Weakness	Y	N	P

Peripheral Vascular

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

Neurological

Dizziness	Y	N	P	Numbness/tingling	Y	N	P
Fainting	Y	N	P	Memory loss	Y	N	P
Seizures	Y	N	P	Paralysis	Y	N	P

Mental/Emotional

Anxiety/nervousness	Y	N	P	Excessive fears	Y	N	P
Depression	Y	N	P	Mood swings	Y	N	P
Excessive anger	Y	N	P	Tension/stress	Y	N	P

Habits

Do you wake rested	Y	N	P
Sleep Well	Y	N	P
Average hours of sleep:	_____		
Enjoy your work	Y	N	P
Watch television	Y	N	P
How many hours/day:	_____		
Work at a computer	Y	N	P
How many hours/day:	_____		
Read	Y	N	P
How many hours/day:	_____		
Take vacations	Y	N	P
Do you use:			
Recreational drugs	Y	N	P
Alcoholic beverages	Y	N	P

What are your main hobbies and interests?

What forms of exercise do you get?

Exercise how often?

Have you been treated for:			
alcohol dependence	Y	N	P
drug dependence	Y	N	P

Infants and Children

Does your child:							
Sleep through the night	Y	N	P	Eat well	Y	N	P
Frequent sore throats	Y	N	P	Frequent earaches	Y	N	P
Constipation	Y	N	P	Diarrhea	Y	N	P
Hyperactive	Y	N	P	Colic	Y	N	P
Constant runny nose	Y	N	P	Lethargic	Y	N	P
Abnormal weight gain/loss	Y	N	P	Irritable	Y	N	P
Behavioral problems	Y	N	P	Skin rashes	Y	N	P
Reaction to vaccines	Y	N	P				