NAME_____

Medical History

Surgeries (include your age and/or date)_____

_____

_____

Other hospitalizations, reason, age and/or date_____

_____

_____

Infections (circle those you have had): Hepatitis Rheumatic Fever TB HPV Pneumonia Herpes Gonorrhea Chlamydia Syphilis Mumps Chickenpox Measles Bladder or Kidney

Medical Illness (circle those you have had): High blood pressure Diabetes Heart Disease Cancer Arthritis Thyroid Disease Depression Other_____

Broken bones or serious injury_____

Immunizations (circle those you have had): Pneumovax Influenza Chickenpox 2nd MMR Hepatitis B Hepatitis A HPV DPT Menactra (meningococcus) Polio Shingles
Tetanus-did it include pertussis/whooping cough? (last given)_____ Other_____

When did you last have these screening tests? Physical_____ Rectal (>40 yrs)_____
Colonoscopy (>50 yrs)_____ Stool Blood Cards (>50 yrs)_____ Cholesterol_____

What are your health concerns? _____

_____

_____

_____

_____

_____

WOMEN ONLY

Are you possibly pregnant or breastfeeding? Y N
Did your mother take hormones (DES) when pregnant with you? Uncertain Y N
Ever have an abnormal PAP smear? Y N
Age at 1st period_____ 1st day last period_____ Last PAP_____ Last Mammogram_____
Problems with periods or premenstrual symptoms?_____
Pregnancies_____ Vaginal_____ Cesarean_____ Miscarriages_____ Abortions_____

NAME_____

Family History

	Age if Living	Age of Death	Major Illnesses, Cause of Death
Father			
Grandfather			
Grandmother			
Mother			
Grandfather			
Grandmother			
Brothers & Sisters			
Children			

***Circle those diseases other blood relatives (aunts, uncles, cousins have had)*:** cancer, diabetes, heart disease, high blood pressure, stroke, TB, thyroid disease, kidney disease, anemia, migraine, mental illness, depression, suicide, alcoholism, drug abuse, asthma, colon polyps, glaucoma, arthritis, high cholesterol, Other _____

Social and Personal History

Current occupation_____ Educational Level_____

Marital status _____single_____Married_____Widowed_____Divorced_____Separated

Who lives at home with you?_____

Do you have a spiritual practice from which you derive benefit? _____

Hobbies and Interests_____

Do you use tobacco or have you used it in the past? How long?_____How much?_____	Y	N
Are you happy with your weight?	Y	N
Do you feel your diet is healthful?	Y	N
Do you exercise regularly? What form & how often?_____	Y	N
Do you feel life is stressful?	Y	N
Do you drink alcohol? If so, how many drinks a week?_____	Y	N
Have you ever had a drinking problem?	Y	N
Do you use marijuana or other illegal drugs?	Y	N
How many caffeine containing beverages do you average per day?_____		
Have you been sexually intimate with a male partner or partners?	Y	N
Have you been sexually intimate with a female partner or partners?	Y	N
What type of birth control or protection do you use?_____		
Have you ever had sex with someone who used IV drugs, had had many other partners, was a prostitute, gay or bisexual man, or whose needle use or sexual past was unknown to you?	Y	N
Have you been exposed to harmful chemicals or radiation?	Y	N
Do you wear a seatbelt?	Y	N
Do you have relationship (spouse, family, friends) problems?	Y	N

NAME____

Nutritional Supplement and Medication Log

Please include all nutritional supplements, over the counter and prescription medications.

Pharmacy ______________________________ Location ______________________________

Medication or Supplement	Dose	Frequency	Reason For Taking	For How Long?	Prescriber

NAME_____

ALLERGIES/ADVERSE REACTIONS TO MEDICATIONS OR SUPPLEMENTS:

Medication or Supplement	Reaction	Approximate date or age of first reaction.

LIST PAST MEDICATIONS USED FOR TREATMENT OF CURRENT CONDITIONS

Medication	Dose	Frequency	Reason For Taking	For How Long?	Reason For Stopping

Name _____

Review of Systems

Circle those you ***now*** have or that have been ***significant*** problems in the past.

Fever or chills
Weight change in past 6 months
Fatigue
Headaches
Seizures or convulsions
Fainting or passing out
Dizziness
Vision problems
Earaches
Hearing difficulties
Ringing in ears
Nosebleeds
Sinus problems
Trouble with teeth or mouth
Hoarseness, prolonged
Breast lump or discharge
Chronic or frequent cough
Coughed or vomited blood
Night sweats
Chest pain
Palpitations
Amnesia

Heart murmur
Swelling of ankles
Nausea
Jaundice
Indigestion or heartburn
Peptic ulcer
Constipation or diarrhea
Abdominal pain
Bloody or tarry stools
Change in bowel movements
Pain or frequent urination
Waking at night to urinate
Control of urine
Difficulty in starting urine
Blood in urine
Discharge from penis
Sexual problems
Vaginal discharge or itching
Inability to have children
Joint pains
Kidney stones
Difficulty swallowing

Tremor/hands shaking
Recurrent backache
Leg pain (walking or at night)
Weakness or paralysis
Numbness or tingling
Sleep problems
Snoring
Nervousness
Depression/crying spells
Difficulty concentrating
Memory loss
Fears
Disturbing thoughts
Varicose veins/phlebitis
Skin problems
Thyroid problems
Increased thirst/hunger
Heat/cold intolerance
Vomiting
Pain in extremities
Shortness of breath