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Patient Health History

A successful patient/practitioner relationship is possible when I have a complete understanding of your past and current health. Thank you for filling out this information to the best of your ability.

Name: ____ Date:______________

Chief Concerns: Please identify and describe the concerns for which you are seeking treatment.

Issue	Past or current treatment/Length of time it has been a problem
____	_______________________________
____	_______________________________
____	_______________________________
____	_______________________________
____	_______________________________
____	_______________________________

1. Why is it important to you to receive health care for these issues?: ____________

____

____

2. Are you currently receiving healthcare? Y N

3. If yes, where and from whom?____

4. If no, when and where did you last receive health care? _____________________

5. Has your case been referred to an attorney? Y N

6. Is there any reason to believe that you are pregnant? Y N

7. Do you have any chronic infectious diseases or STD? Y N If yes, please explain:

____

8. Are you currently suffering from any chronic illness? ____________________________

9. *If applicable*, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include the type of reaction):

a. ____
b. ____
c. ____

10. Please circle any of the following medications that you are currently taking:

Laxatives	Pain Relievers	Antacids	Thyroid Medication
Birth Control	Menopause Med.	Antibiotics	Sleeping Pills
Cortisone	Blood Pressure Med.		

11. Please list any prescription medications, over-the-counter medication, vitamins, and supplements that you are currently taking: ______________________________________

____

____

12. Height:______ Weight:______ Past Max/Min Wt._____/_____ When?_____/_____

13. Blood Pressure: What is your most recent BP reading? ______/______ When was last reading? __________

14. Hospitalizations and Surgeries:

Reason When

____
____
____
____

15. X-Rays/CAT Scans/MRI/NMR/Special Studies:

Reason When

____

____

____

____

16. Family History:

Family History	Age if living	Health E/excellent G/good P/Poor	Age of death if deceased	Cause of death
Mother				
Father				
Brothers				
Sisters				
Spouse/Partner				
Children				

Please list any family members who have had the conditions below:
Cancer (please list type): ____
Diabetes: ____
Heart Disease:____
High BP: ____
Stroke: ____
Mental Illness: ____

17. Gastrointestinal Health

I have (check all that apply):
__Bloating __Gas __Constipation __Diarrhea __Stomach Pains
__Heartburn __Belching __Nausea __Vomiting __Ulcers
__Hemorrhoids __Burning Around Anus __Hernia
__Other (describe)____

18. Emotional Health and Sleeping Habits

Stress: Do you feel that your life is stressful? __yes __no
Describe:____

What emotion(s) do you think you experience most often?
__Joy __Grief __Fear __Anger __Worry __Sadness

Do you have (check all that apply):
__Panic attacks __Depression __Anxiety __Suicidal thoughts
__Bad temper __Nervousness __Poor memory __Difficult concentration

How long do you normally sleep? ____hours per night
I have difficulties with (check all that apply):
__falling asleep __Staying asleep __Disturbed sleep __Waking up at night

19. Genitourinary and Sexual Health

Urination: How often? __times per day Color: __pale yellow __dark yellow/orange

I have/had (check all that apply):
__Pain on urination __Frequent urination __Urgent urination
__Blood in urine __Unable to hold urine __Incomplete urination
__Incontinence __Wake to urinate __Bed wetting
__Kidney stone __Venereal disease __Other (describe)________

How would you define your sexual energy? __low __normal __high
Do you have pain during intercourse? __yes __no
Do you have difficulty achieving an orgasm? __yes __no

I have/have had (check all that apply):

__Irregular periods __Fibrocystic breast disease
__No periods __Blood/mucus discharge from nipples
__Painful periods __Menopause
__Spotting between periods __Premenstrual tension
__Heavy flow __Light flow
__Clots in blood __Vaginal discharge
__Vaginal itching/burning __Vaginal dryness
__Sores on genitalia __Uterine prolapse
__Other (describe)____

I have/have had (check all that apply):

__Prostate problems __Premature ejaculation __Penis blood/mucous discharge
__Erectile dysfunction __Nocturnal emission __Other___________________

20. Muscles, Joints and Bones

Do you have areas of pain and tightness? __yes __no If yes, where?________________
I have (check all that apply):

__Swollen joints __Arthritis/joint pain __Tendonitis
__Jaw problems __Rheumatism __Bone pain
__Muscle pain __Repetitive strain injury __Muscle cramping

21. Eyes, Ears, Nose, Throat and Head

I have (check all that apply):

__Painful eyes __Red eyes __Itchy eyes __Spots in the eyes
__Blurred vision __Poor vision __Ringing in the ears __Poor hearing
__Earaches __Nose bleeds __Runny nose __Sinus problems
__Sore throat __Chronic cough __Swollen glands __Lumps in throat
__Dry mouth __Excessive saliva __Sores on lips/tongue __Teeth problems
__Gum problems __Facial pain __Headaches __Migraines
__Other (describe)____

22. Cardiovascular Health

Blood pressure __/__ Have you been diagnosed with heart problems? __yes __no
I have (check all that apply):

__Chest pain	__Palpitations	__Irregular heartbeat
__Blood clots	__Fainting	__Difficulty breathing
__Poor circulation	__Varicose veins	__Phlebitis

__Other (describe)____

23. Skin and Hair

I have/often have (check all that apply):

__Rashes	__Hives	__Ulcerations	__Eczema	__Fungal infections
__Psoriasis	__Acne	__Dandruff	__Itching	__Hair loss

__Other (describe)____

24. Please list typical Food Intake:

Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____

Please list hobbies and exercise habits:

____

____

Please rate your social/family support at this time in your life on a scale from 1 to 10:

Not very supportive Very Supportive
0 1 2 3 4 5 6 7 8 9 10

Is it okay if I contact you in six months to see how you are doing? YES NO

Is there anything else that you would like to share?

THANK YOU FOR YOUR TIME!