

Reason for this appointment? _____

When did this issue begin? _____

Was there an event surrounding the issue (i.e. accident/event) _____

Have you been given a diagnosis? _____ If so, what? _____

What kinds of treatment have you tried? _____

Have they helped alleviate the condition/problem? _____

Are you currently receiving treatment? _____ If so, please describe: _____

List any other problems/concerns: _____

ALLERGIES:

Drug allergies (penicillin, etc.) _____

Allergies to foods, pollens, etc: _____

MEDICAL STATUS

General Health: Excellent Good Fair Poor Height _____ Weight _____

Current Medications (vitamins, prescriptions, herbal or otherwise)

Medication name	Date started	Date stopped	Dosage	# per day

Past Medication Use:

Infancy

Childhood

Teens

Adulthood

Antibiotics				
Steroids				

Who is your primary care physician? _____ Phone: _____

Have you seen a physician for any reason in the past 3 months? Y or N For what? _____

Have you had blood work in the past 3 months? Y or N Was it Normal? Y or N

If abnormal please describe: _____

List any other Health Care providers: _____

MEDICAL HISTORY

Illnesses: _____

Significant Trauma (i.e. Motor Vehicle Accidents, Falls, etc): _____

Broken bones or dislocations: _____

X-ray, MRI, CAT or Bone Scans (where and when) what was found? _____

Do you have or have you ever had any infectious disease, recurring infections or inflammations? Y or N

Describe: _____

How many times each year do you have a Cold, Sinusitis, the Flu, Sore throat, Bronchitis? _____

How long do they usually last and are they severe? _____

What do you feel your weakest organ system is? (i.e. heart, kidney, liver, lungs etc) _____

HOSPITALIZATIONS/OPERATIONS

Date	Diagnosis	Surgery	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SYMPTOMS CHECKLIST:

Circle those you presently have (during the last few weeks). **Underline** those you've had previously.

GENERAL

Headache
Fever
Chills
Sweats
Fainting
Dizziness
Imbalance
Seizures
Epilepsy
Sleeping Difficulties
Quality of Sleep _____
Sleep _____ hrs/night
Feel run down
Fatigue
Hypoglycemic
Nervousness/Anxiety
Panic Attacks/Phobias
Depression
On Anti-Depressants
Mental Disorder
Alcohol Problems
Drug Problems
Diabetes
Neuralgia
Anemia
Cancer
Memory Loss
Scarlet Fever
Rheumatic Fever
Measles
Mumps
Chicken Pox
Weight Loss _____ lbs
Weight Gain _____ lbs
Other _____
EAR NOSE THROAT
Eye Strain/Pain
Failing Vision
Blurred Vision
Glaucoma
Sensitive to Light
Hearing Problems
Ear Ringing/Noises
Ear Discharge
Sinus Infection
Nose Bleeds
Nasal Obstruction

Nasal Drainage
Sore Throat
Hoarseness
Loss of Voice
Dental Decay
Mouth Sores
Gum Disease
Teeth Grinding
Jaw Pain
Frequent Colds
Thyroid Condition
Tonsillitis
Enlarged Glands
Hay Fever
Other _____

SKIN

Rashes
Skin Eruptions
Eczema
Itching
Bruise Easily
Dry Skin
Boils
Moles
Varicose Veins
Sensitive Skin
Hair Loss
Other _____

RESPIRATORY

Asthma
Allergies
Pneumonia
Emphysema
Tuberculosis
Bronchitis
Pleurisy
Chronic Cough
Spitting Blood
Spitting Phlegm
Chest Pain
Difficult Breathing
Shortness of breath
Other _____

CARDIOVASCULAR

Rapid Heartbeat
Slow Heartbeat

Irregular Heartbeat
High blood pressure
Blood Clots
Low Blood Pressure
Pain over Heart
Pacemaker
Hardening of Arteries
Ankle Swelling
Poor Circulation
Stroke/TIA
Other _____

MUSCLE & JOINT

Stiff Neck
Back Pain
Gout
Swollen Joints
Painful Joints
Arthritis
Bursitis
Tendonitis
Muscle/Joint Weakness
Muscle spasms/cramps
Foot Trouble
Spinal Curvature
Osteoporosis
Other _____

GENTOURINARY

Frequent Urination
Night Urination _____ times
Painful Urination
Blood in Urine
Pus in Urine
Kidney Infection or Stones
Bed-wetting
Inability to control urine
Prostate trouble
Hernia
Sexually transmitted disease
Sexual Dysfunction/Difficulty
Other _____

GASTROINTESTINAL

Trouble Swallowing
Bad breath
Indigestion/Heartburn
Nausea
Poor Appetite

Belching/Gas
Excessive Hunger
Cravings
Eating Disorder
Vomit Blood
Stomach Pain
Cramping Pain
Ulcers
Abdomen Distention
Constipation
Diarrhea
Colitis/IBS
Appendicitis
Hemorrhoids
Intestinal Worms
Parasites
Hepatitis
Liver Problems
Gallbladder Problems
Jaundice
Bad Body Odor
Other _____

PAIN ASSESSMENT:

Did your pain or symptoms come on gradually or suddenly?_____ Is it constant or comes and goes?_____

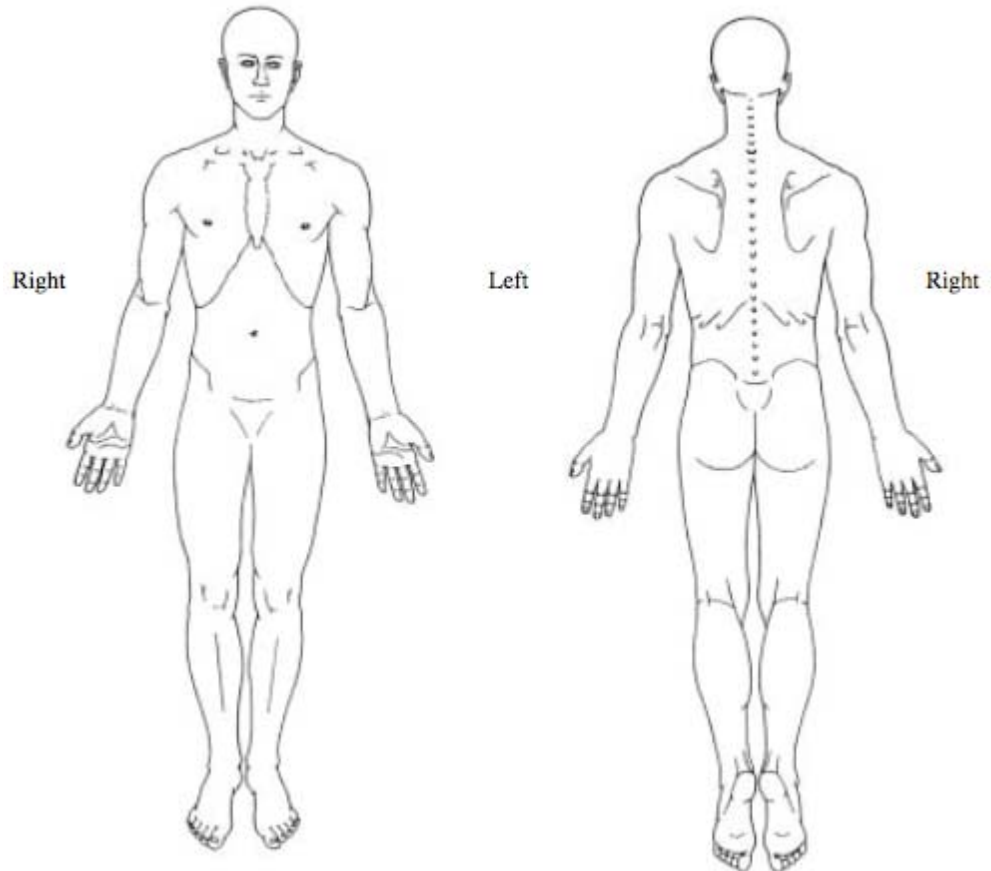
What time of the day is the pain the worst? Morning, Afternoon, Evening, Night, Constantly?_____

What makes the symptoms worst? _____

What makes your pain or symptoms better? _____

PATIENT PAIN DRAWING

Please place the symbol(s) on the body in the area(s) that best describes the pain or discomfort you are having.



- PP** Sharp pain
- DD** Dull Pain
- BB** Burning
- NN** Numbness
- TT** Tingling
- SS** stabbing
- AA** Ache
- Th** Throbbing

On a scale of 0-10 with 0 being pain free and 10 being constant, disabling pain: Rate each area of pain.

Other than the health concerns you already have indicated which of the following would you additionally like our support (Check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Have more energy/vitality | <input type="checkbox"/> Slow down accelerated aging | <input type="checkbox"/> Be happier |
| <input type="checkbox"/> Sleep better | <input type="checkbox"/> Monitor my body's aging | <input type="checkbox"/> Be less depressed |
| <input type="checkbox"/> Be less tired after lunch | <input type="checkbox"/> Maintain a healthier life longer | <input type="checkbox"/> Not so many drugs |
| <input type="checkbox"/> Get less colds and flu | <input type="checkbox"/> Be stronger | <input type="checkbox"/> Be less moody |
| <input type="checkbox"/> Get rid of allergies | <input type="checkbox"/> Reduce body fat | <input type="checkbox"/> Think more clearly |
| <input type="checkbox"/> Have more sex drive | <input type="checkbox"/> Be more flexible | <input type="checkbox"/> Improve my memory |
| <input type="checkbox"/> Reduce my risk of degenerative disease | <input type="checkbox"/> Improve my skin quality/youthfulness | <input type="checkbox"/> Learn how to reduce stress |

Dietary Preferences

Sample of day's menu:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drink: _____

Dietary Restrictions: _____

What allergies to foods, drugs or inhalants are you aware of and how do you react? _____

Habits

Water: Glasses per day of: Tap _____ Bottled _____ Filtered _____

Alcohol: Wine # of glasses /day or week _____ Beer # glasses/ day or week _____

Liquor: #of ounces day or week _____

Caffeine: Coffee - cups/day _____ Tea - cups/day _____

Soda with caffeine: #of cans/day _____ Soda without caffeine: #of cans/day _____

Chocolate or other sweets How much day/ week _____

Smoke cigarettes: #/day _____ Previously? _____ How much? _____ How long? _____

Other tobacco #/day _____ Previously? _____ How much? _____ How long? _____

Mood altering substance use (i.e. marijuana, cocaine- past and present) _____

Exposed to second hand smoke or pollution? _____ Previously? _____ How much? _____ How long? _____

Chemicals at work or hobbies? _____ Previously? _____ How much? _____ How long? _____

Exercise: Type _____ Frequency _____

Do you have your teeth cleaned regularly? _____ Do you floss your teeth regularly? _____

How many times a day/week do you have bowel movements:? _____ times per day/week (circle one)

Are your bowel movements loose, hard, difficult to pass, strong smelling, accompanied by gas? (Please circle all that apply.)What is the typical color? Blackish, brown, clay, greenish. Ever bloody?

On a scale of 1-10 (10 highest) what number do you believe reflects your current level of stress? _____

Please list the 3 or more most significant stressful events in your life:

Please indicate those continuing to impact your life.

Family History

Member	Living?	Age?	Major Diseases*?	Cause of Death and Age
Mother				
Father				
Sister(s)				
Brother(s)				
Maternal Grandma				
Maternal Grandpa				
Paternal Grandma				
Paternal Grandpa				

*Alcoholism, High Blood Pressure, Cancer, Diabetes, Heart Disease, Arthritis, Asthma, Allergies, Depression, Other Addiction, Other illness.

FOR MEN ONLY

Please check or explain if applicable:

- Reduced Sexual Desire _____
- Premature Ejaculation _____
- Seminal Emission _____
- Impotence _____
- Painful or Dribbling Urine _____
- Pain associated with Genitals _____

FOR WOMEN ONLY

- Irregular Periods Painful Periods PMS Light Flow Heavy Flow Clots Vaginal Discharge
- Endometriosis PCOS Ovarian Cysts Uterine Fibroids Pelvic Surgery

BREASTS: Pain/Tenderness Lumps Cysts Discharge Fibroids

Date last period began: _____ Date Prior period began _____
 Age of first menstrual cycle _____ Age/Date of last menstrual cycle _____
 Uterus/ovaries still in tact? _____ If no, date removed and why: _____

Have you reached menopause? _____ List any symptoms you are experiencing _____

Date of last Pap Smear/Pelvic Exam: _____ Pap Normal? Yes/No (circle one)

Have you ever had an abnormal Pap? _____ When? _____ Results _____ Treatment _____

Are you sexually active? _____ Do you practice safe sex? _____ Current birth control method _____

Past birth control methods _____

Pregnancies _____ Births _____ Miscarriages _____ Abortions _____

Normally (not on pills) the number of days from the start of one period to the start of the next? _____

Number of days of flow: _____ Amount of bleeding: _____ Amount of cramps: _____

Color of blood (i.e. bright red/purplish/dark red etc) _____ Clots? _____

Premenstrual symptoms: _____ Starting when? _____

Any current changes in your normal pattern? _____

Any bleeding between periods? _____ When? _____ Any unusual vaginal discharge or itching? _____

How long? _____ Past treatment? _____

Any sexual concerns to discuss? _____ Any past history of tubal infection? _____

Any past history of sexually transmitted diseases? _____

Other/Additional comments: _____

Thank you ☺