PATIENT HEALTH HISTORY FORM (Page 1)

Patient Name:_____ DOB:_____ Age:____ Sex:____ Date:_____

Current Health History

Reason for your visit today: _____

_____

Is the above related to a work injury or car accident? ❑Yes ❑No Date injury occurred: _____

How does this condition affect you? Does it interfere with: ❑ your ability to work ❑ physical activity ❑ sleep ❑ ability to care for yourself/family ❑ ability to do household chores ❑ other: _____

_____

Do any family members have this condition? ❑Yes ❑No Relationship to you: _____

Treatment(s) you've had for this condition: _____

_____

Additional health concerns you have (list in order of importance): _____

_____

Do you currently have any infectious diseases? ❑Yes ❑No Please describe: _____

Primary care provider (name/location): _____

Specialists you currently see (name/specialty): _____

Current Medications (prescription AND non-prescription)

Medication Name	Dosage	Reason taken	Medication Name	Dosage	Reason taken

Vitamins, Supplements, Herbs (list all that you currently take)

Allergies/Hypersensitivities

(List foods, medications, plants, and any other substances you are allergic/sensitive to and describe your reaction to them)

Family Medical History (check/complete any that apply)

	Mother	Father	Sisters	Brothers	Children
Age (if living)					
Age at death					
Cause of death					
Heart disease					
High blood pressure					
Diabetes (Type I or II)					
High cholesterol					
Cancer (list type)					
Stroke					
Substance abuse					
Mental health issues					

Surgeries/Hospitalizations

Date	Type of Surgery/Reason in Hospital	Date	Type of Surgery/Reason in Hospital

XRays, CT Scans, MRIs, any other special imaging you've had

Date	Type of Imaging/Reason it was done	Date	Type of Imaging/Reason it was done

PATIENT HEALTH HISTORY FORM (Page 2)

Patient Name:_____ DOB:_____ Age:____ Sex:____ Date:_____

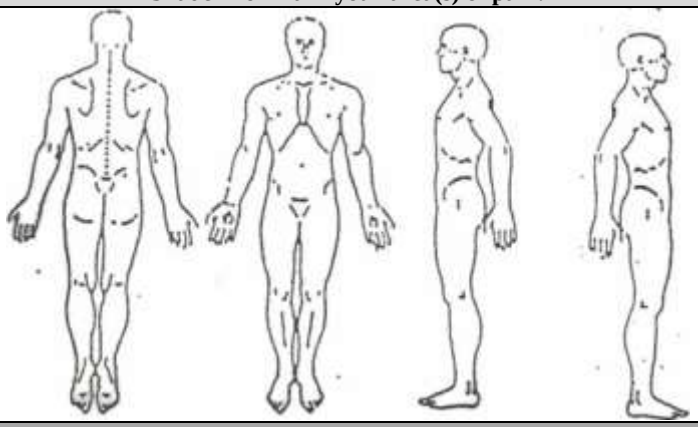
Personal Medical History (check any you have currently or have had in the past)

Condition	Now	Past	Condition	Now	Past	Condition	Now	Past
Addiction:_____			Epilepsy			Migraines		
Anemia			Fainting			Mononucleosis		
Anxiety			Fibromyalgia			Multiple sclerosis		
Arthritis: osteo or rheumatoid			Gallbladder disease/stones			Neurological disease		
Asthma			Heart disease/heart attack			Numbness/tingling		
Autoimmune disease			Hepatitis: A B C			Osteoporosis		
Blood clots			Herpes: oral genital			Pacemaker		
Bronchitis			High blood pressure			Paralysis		
Bruise or bleed easily			High cholesterol			Pneumonia		
Cancer (type_____)			HIV/AIDS			Rash:_____		
Celiac disease			Hyperthyroid (high)			Seizures		
Chronic fatigue syndrome			Hypothyroid (low)			Sexually transmitted disease		
COPD			Irritable bowel syndrome			Sleep apnea		
Crohn's disease			Inflammatory bowel disease			Slow wound healing		
Depression			Kidney disease/stones			Stomach ulcers		
Diabetes			Liver disease/cirrhosis			Tuberculosis		
Difficulty concentrating			Loss of balance			Ulcerative colitis		
Dizziness			Memory problems			Varicose veins		
Emphysema			Mental illness: _____			Vertigo		

Other serious illness, injury or trauma you have now or in the past:

Body Pain

Shade in or mark your area(s) of pain:



Check all that apply

- ❑ Headache/migraine
- ❑ Sinus pain
- ❑ Eye pain
- ❑ Ear pain
- ❑ Jaw pain/TMJ
- ❑ Tooth pain
- ❑ Neck pain
- ❑ Shoulder pain
- ❑ Upper arm pain
- ❑ Elbow pain
- ❑ Forearm pain
- ❑ Wrist pain
- ❑ Hand pain
- ❑ Finger pain
- ❑ Chest pain
- ❑ Rib pain
- ❑ Upper abdominal pain
- ❑ Lower abdominal pain
- ❑ Pelvic pain
- ❑ Upper back pain
- ❑ Lower back pain
- ❑ Buttock pain
- ❑ Hip pain
- ❑ Thigh pain
- ❑ Knee pain
- ❑ Lower leg pain
- ❑ Ankle pain
- ❑ Foot pain
- ❑ Toe pain
- ❑ Muscle spasms/cramping

Lifestyle

Occupation: _____ Do you enjoy your work? ❑Yes ❑No

Why/why not? _____

What kinds of foods do you eat in a typical day:

Breakfast: _____ Lunch: _____

Dinner: _____ Snacks: _____

Do you drink alcohol? ❑Yes ❑No How much per day/week?_____

caffeinated drinks? ❑Yes ❑No How much per day/week?_____

How much water do you drink per day? _____

Do you smoke? ❑Yes ❑No # years smoking: _____ # cigarettes/packs per day: _____

Do you exercise regularly? ❑Yes ❑No What kind of exercise do you do, how often do you do it and for how long each session?_____

How many hours of sleep do you usually get per night? _____

PATIENT HEALTH HISTORY FORM (Page 3)

Patient Name:_____ DOB:_____ Age:____ Sex:____ Date:_____

Menstrual History

❑I am postmenopausal (skip to Other Reproductive History) ❑I am pre- or peri-menopausal (continue with Menstrual History)
Age at first menses: _____ Date your last period started: _____ Are your periods regular? ❑Yes ❑No
# of days from the start of one period to the next: _____ # days you usually bleed during your period: _____
Is your menstrual blood: ❑Bright red ❑Pale pink ❑Dark Purple ❑Brownish ❑Thick/viscous ❑Thin/watery
❑Medium (not thick or thin) Do you have clots: ❑Yes ❑No Color/Size: _____
Maximum # of pads/tampons you use on the heaviest day of flow:_____
Do you currently have any of the following menstrual issues? ❑Not getting periods ❑Having irregular periods
❑PMS (circle all that apply): bloating breast tenderness headaches emotional changes:_____
❑Cramps: ❑Mild ❑Moderate ❑Severe Starting when/lasting how long?_____
❑Pain with ovulation ❑Midcycle spotting or bleeding
Any recent shift toward: ❑Heavier flow ❑Lighter flow ❑Longer Flow ❑Shorter Flow ❑More clots
❑More/worse cramping ❑Missed periods ❑Other:_____
Have you been diagnosed with any of the following: ❑PCOS ❑Endometriosis ❑Fibroids ❑Ovarian cysts
Are you sexually active? ❑Yes ❑No Using birth control? ❑Yes ❑No Method:_____

Other Reproductive History

How many of the following have you had? Pregnancies: ___ Live Births: ___ Miscarriages: ___ Abortions: ___
Are you currently pregnant? ❑Yes # of weeks: _____ ❑No ❑ Maybe – I'm not sure yet
Are you having/have you ever had any trouble conceiving? ❑Yes ❑No ❑Have never tried to get pregnant
Have you had any surgeries in the reproductive system? If yes, what kind? _____
_____
Have you been diagnosed with: ❑Breast cancer ❑Uterine cancer ❑Ovarian cancer ❑Cervical cancer
Do you have any of the following: ❑Breast pain ❑Breast lumps ❑Frequent vaginal infections ❑Vaginal pain
❑Vaginal dryness ❑Pain with sex ❑Low libido ❑Menopausal issues: _____
Date of last PAP smear: _____ Was it normal? ❑Yes ❑No:_____
Date of last mammogram: _____ Was it normal? ❑Yes ❑No:_____