Date: _____

Patient Name: _____ Date of Birth: _____

** An accurate medical, social and family history is very important for us to know in order to better assess your current medical health and influences on future health and well-being.*

Review of Systems

Please circle any of the following you are currently experiencing:

GENERAL	EYES	ENT	CARDIOVASCULAR	RESPIRATORY	GASTROINTESTINAL	GENITOURINARY
Fatigue	Blurred Vision	Hearing Problems	Chest Pain/Pressure	Cough—Acute	Abdominal pain	Painful Urination
Fever	Eye Drainage	Ear Ringing	Dizziness	Cough—Chronic	Diarrhea	Blood in Urine
Night Sweats	Eye Pain	Nosebleeds	Palpitations	Shortness of breath	Blood in stool	Frequent Urination
Weight Gain	Light Sensitivity	Hoarseness	Feet Swelling	Blood-Tinged Sputum	Nausea	Incontinence
Weight Loss	Double Vision	Sore Throat	Varicose Veins	Wheezing	Vomiting	Flank Pain

MUSCULOSKELETAL	SKIN/BREASTS	NEUROLOGICAL	HEMATOLOGIC/LYMPHATIC	ENDOCRINE	MALE	PSYCHOLOGIC
Joint Pain	Lesions/Moles	Fainting	Easy Bruising	Hair Loss	ED	Depression
Back Pain	Itching	Headaches	Excessive Bleeding	Heat/Cold Intol	Impotence	Anxiety
Joint Stiffness	Rash	Confusion/Memory Loss	Lymph Node Swelling	Excess Thirst		Severe Stress
Extremity Pain	Breast Mass	Numbness/Tingling	Anemia	Excess Sweat		Sleep Disturbance
Muscle Pain	Breast Tenderness	Seizure				

Allergies

☐ NONE ☐ MEDICATIONS ☐ LATEX ☐ FOOD ☐ OTHER

List Allergies and Reactions:

_____ _____

_____ _____

Prescription/Non-prescription Medications/Vitamins/Supplements

Medication Dose/Number Per Day	Medication Dose/Number Per Day	Medication Dose/Number Per Day
1. _____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11 _____
4. _____	8. _____	12. _____

Supplements Current Use: Appetite Suppressant "Fat Burners" Multivitamin Creatine Ginseng SAM-e DHEA MaHuang Xenadrine Ephedrine Metabolife Other

Please list your preferred pharmacy: _____

Past Medical History

Please check if you have or have had:

☐ Arthritis ☐ Asthma ☐ Bleeding Difficulties ☐ Depression ☐ Diabetes Mellitus ☐ Emphysema ☐ Heart Disease

☐ Hepatitis ☐ High BP ☐ High Cholesterol ☐ HIV ☐ Insomnia ☐ Kidney Disease/Stones

☐ Migraines ☐ Osteoporosis ☐ Seizure Disorder ☐ STD ☐ Stroke ☐ TB ☐ Thyroid Disease

☐ Cancer (Type/Treatment) _____

Patient Name: _____ Date of Birth: _____

Assigned Sex *(Optional)*

Assigned Sex at Birth: Male Female

Gender Identity: Male Female Transsexual Male Transsexual Female Genderqueer, Neither Exclusively Male nor Female Other

Sexual Orientation: Heterosexual Homosexual Bisexual Other: _____

Gynecologic/Obstetric History

Date of last menstrual cycle: _____ Age at onset of periods: _____ Age at onset of menopause: _____

Problems with menstrual cycles:

_____ None _____ Irregular frequency/duration _____ Dysmenorrhea _____ Heavy Bleeding _____ Other

Number of pregnancies: _____ Problems with pregnancies: _____

Number of live births: _____ Number of miscarriages: _____ Number of Abortions: _____

Current birth control: _____

Date of last pap smear: _____ History of abnormal pap smears? ☐ No ☐ Yes Abnormalities: _____

Prevention

If over age 30, have you had your cholesterol level checked in the past 5 years? ☐ No ☐ Yes

Have you ever had a mammogram? ☐ No ☐ Yes If yes, date of last mammogram: _____

Any abnormalities noted? ☐ No ☐ Yes _____

Have you ever had a colonoscopy? ☐ No ☐ Yes If yes, date of last colonoscopy: _____

Any abnormalities noted? ☐ No ☐ Yes _____

Have you ever had a bone density or DEXA test? ☐ No ☐ Yes If yes, date of last screening: _____

Any abnormalities noted? ☐ No ☐ Yes _____

Date of last dental exam: _____ Date of last eye exam: _____

Immunizations

☐ Tetanus/Yr _____ ☐ Influenza/Yr _____ ☐ Pneumonia/Yr _____ ☐ Shingles/Yr _____

☐ HPV vaccine: #1 _____ #2 _____ #3 _____ ☐ Other/Yr _____

Past Surgical History

SURGERY	DATE	SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name: _____ Date of Birth: _____

Family History

Illness Which Family Members? Illness Which Family Members?

Key: *MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather*

Cancer/Type? _____

Hypertension _____ Heart Disease _____

Diabetes _____ Stroke_____

Mental Disease _____ Alcoholism_____

Glaucoma _____ Bleeding Disorder_____

Osteoporosis _____ Thyroid Disease_____

Other _____

Father: Living / Deceased Age ____ Cause of Death _____Brothers: # Alive ____ # Deceased____ Age____ Cause of Death _____

Mother: Living / Deceased Age ____ Cause of Death _____Sisters: # Alive ____ # Deceased____ Age____ Cause of Death _____

Social History

Spiritual and/or Religious Preference (*optional*): _____

Education Background: High School College – 2 yr College – 4 yr Post-Graduate

Occupation**:** _____ Are you satisfied with your job? _____

Marital Status: Single Married Separated Divorced Widowed

Number of Children: _____

Who lives in your current household? _____

Do you feel safe at home? _____ If not, what makes you fearful? _____

Has anyone ever hit, kicked, pushed or verbally intimidated you? _____

Do you have any current major home, work, social or financial stressors affecting your life and/or well-being?

_____

Do you have difficulty sleeping? _____ How many hours of sleep do you get each day? _____

Hobbies/Recreation _____

Exercise: ☐ None Type of Exercise: _____

Frequency: Days per week/Time per session _____

Nutrition:

Are you happy with your current weight? Yes No If no, why not? _____

Are you currently on a special diet? Yes No If yes, what kind? _____

Do you eat 1-2 servings of fruit and 3-6 servings of vegetables each day? Yes No

How many glasses of water do you drink each day? _____

How would you rate your overall nutrition? Terrific Good Fair Poor Terrible

Tobacco/Alcohol/Caffeine

Tobacco Never smoked _____ Past Smoker: Cigarettes Quit Date _____ # Packs/Day _____

Cigars Quit Date _____ # Packs/Day _____

Current Smoker: ____ Every Day Smoker ____ Intermittent Smoker # Cigarettes/Cigars Per Day _____

Smokeless Tobacco: ____ Current Use # Cans/Pouches per Day _____

Alcohol None _____ Frequency: ____ Rare ____ Social ____ Regular Use ____ Binges

Quantity: # Drinks per Day _____ # Drinks per Week _____ # Drinks per Month _____

Types of Alcohol: _____ Previous attempt to quit? _____

Caffeine None ___ Coffee Tea Soda # Servings per Day ____

Illicit Drug Use: Current Use: ____ No ____ Yes Type: _____

Prior Use: ____ No ____ Yes Type: _____ Quit Date: _____