Medical History

Name ______________________________ Date _________ MR# ______________

What is/are your chief symptom(s) or medical problems at this time?__________
____
____
____

SURGICAL HISTORY: ☐ None or please list: Operation / Reason / Date:

____
____
____

Surgical Complications?____

MEDICAL HISTORY:

Please list any significant medical illness . Check box if hospitalization:

____ ☐
____ ☐
____ ☐
____ ☐

FAMILY HISTORY: Please indicate the health problems of your family:

Check if Deceased	Current Age or Age at Death	Health Problems or Cause of Death
☐ Father	_______	________________________________
☐ Mother	_______	________________________________
☐ Brothers	_______	________________________________
☐ Brothers	_______	________________________________
☐ Brothers	_______	________________________________
☐ Sisters	_______	________________________________
☐ Sisters	_______	________________________________
☐ Sisters	_______	________________________________

Medical History (continued)

FAMILY HISTORY (continued):

Check if Deceased	Current Age or Age at Death	Health Problems or Cause of Death
☐ Children	______	______________________________
☐ Children	______	______________________________
☐ Children	______	______________________________
☐ Spouse/Partner	______	______________________________
☐ Others	______	______________________________
☐ Others	______	______________________________

Has anyone in your family had:

Diabetes? ☐ Yes ☐ No Relation ______________________

Thyroid disease? ☐ Yes ☐ No Relation ______________________

Breast or ovarian cancer? ☐ Yes ☐ No Relation ______________________

ALLERGIES: ☐ None or list Drug / Reaction:

____

____

____

____

Others (food, bee stings, etc.) ______________________________

____

____

Lactose intolerence ☐

Peanut allergy ☐

Medical History (continued)

PLEASE BRING ALL MEDICATIONS AND SUPPLEMENTS TO YOUR APPOINTMENT!

MEDICATIONS now being taken: ☐ None

Medication Dosage Frequency

____

____

____

SUPPLEMENTS: ☐ None

____

____

____

SOCIAL HISTORY:

Birthplace ______________________________

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated How long? ____________

Children: # ______ Ages: ______________________________

With whom do you live?

____

____

Occupation/s - past and present?

____

____

____

GENERAL:

Are you frequently ill? .... ☐ Yes ☐ No

Are you having fever ☐ chills ☐ sweats ☐? .... ☐ Yes ☐ No

Have you lost ☐ or gained ☐ weight recently? .... ☐ Yes ☐ No

What is the most you have ever weighed? _______________ When? __________________

Medical History (continued)

Do you have a loss of appetite? ☐ Yes ☐ No
Have you difficulty falling ☐ or staying ☐ asleep? ☐ Yes ☐ No
Are you incapable of experiencing pleasure? ☐ Yes ☐ No
Do you suffer from complete exhaustion? ☐ Yes ☐ No
Have you ever been treated for an emotional illness? ☐ Yes ☐ No
Are you depressed? ☐ Yes ☐ No
Do you have feelings of worthlessness or guilt? ☐ Yes ☐ No
Do you have difficulty concentrating? ☐ Yes ☐ No
Do you have recurrent thoughts of death or suicide? ☐ Yes ☐ No
Are you considered a nervous person? ☐ Yes ☐ No

Concerning alcohol consumption:

Has there been a period when you consumed more than you presently do? ☐ Yes ☐ No
Have you ever felt you ought to cut down on your drinking? ☐ Yes ☐ No
Do people annoy you by criticizing your drinking? ☐ Yes ☐ No
Have you ever felt guilty about your drinking? ☐ Yes ☐ No
Have you ever had a drink first thing in the morning to steady your nerves or reduce a hangover? ☐ Yes ☐ No

Do you wear seatbelts? ☐ Yes ☐ No
Are there any personal problems you would like to discuss such as family or marital problems, concerns about AIDS, other diseases, or preventive health issues, etc? ☐ Yes ☐ No
Are you on disability? ☐ Yes ☐ No
Is litigation pending regarding a medical problem? ☐ Yes ☐ No

SKIN:

Have you had a skin rash ☐ or itching ☐ ? ☐ Yes ☐ No
Have you had lumps ☐ growths ☐ or changing moles ☐ ? ☐ Yes ☐ No

Medical History (continued)

Have you had significant changes in hair ☐ or nails ☐ ? ☐ Yes ☐ No

Do you have a history of skin cancer? ☐ Yes ☐ No

Have you experienced skin reactions to the sun other than sunburn? ☐ Yes ☐ No

EYES:

Have you had double vision ☐, blurry vision ☐, or blind spots ☐ ? ☐ Yes ☐ No

Do you wear glasses ☐ or contact lenses ☐ ? ☐ Yes ☐ No

Do you have glaucoma ☐ or cataracts ☐ ? ☐ Yes ☐ No

Have you had laser treatment ☐ or surgery ☐ on your eyes? ☐ Yes ☐ No

Have you had any eye injuries or infections? ☐ Yes ☐ No

When was your last eye check? ____________________

When was your last glaucoma test?________________

EARS:

Do you have any current ear problems? ☐ Yes ☐ No

Are you hard of hearing? ☐ Yes ☐ No

Do you have ringing in the ears? ☐ Yes ☐ No

When was your last hearing test?___________________

NOSE AND THROAT:

Have you had sinus trouble? ☐ Yes ☐ No

Do you have hay fever? ☐ Yes ☐ No

Have you had hoarseness or change in voice? ☐ Yes ☐ No

Do you have significant alteration in taste or smell? ☐ Yes ☐ No

Do you have nasal polyps? ☐ Yes ☐ No

Any history of radiation therapy to the face or neck? ☐ Yes ☐ No

Any history of thyroid disease? ☐ Yes ☐ No

Medical History (continued)

CHEST:

When was your last chest x-ray?________________

Question	Yes	No
Was it abnormal?	☐ Yes	☐ No
Have you had asthma or wheezing?	☐ Yes	☐ No
Do you have shortness of breath at rest ☐ with exertion ☐ or at night ☐ ?	☐ Yes	☐ No
Do you have a frequent cough?	☐ Yes	☐ No
Have you ever coughed up blood?	☐ Yes	☐ No
Have you been exposed to asbestos?	☐ Yes	☐ No

HEART:

Question	Yes	No
When was your last electrocardiogram? ______ Abnormal?	☐ Yes	☐ No
Do you have any heart problems?	☐ Yes	☐ No
Do you have high blood pressure?	☐ Yes	☐ No
Do you have an elevated cholesterol level?	☐ Yes	☐ No
Have you ever suffered a heart attack?	☐ Yes	☐ No

If yes, when ______________________

Question	Yes	No
Do you have any chest pain or discomfort?	☐ Yes	☐ No

How many pillows do you sleep on?___________

Question	Yes	No
Are your ankles often definitely swollen?	☐ Yes	☐ No
Are you bothered by thumping, racing or skipping of the heart?	☐ Yes	☐ No
Have you ever been told you have a heart murmur?	☐ Yes	☐ No
Have you ever had a blood clot or thrombophelebitis?	☐ Yes	☐ No

GASTROINTESTINAL:

Question	Yes	No
Do you have trouble swallowing?	☐ Yes	☐ No
Do you regularly have heartburn?	☐ Yes	☐ No
Are you troubled by nausea or vomiting?	☐ Yes	☐ No
Do you have abdominal pain?	☐ Yes	☐ No

Medical History (continued)

Have you ever been diagnosed as having an ulcer ☐ or gallbladder disease ☐ ? ☐ Yes ☐ No

Have you had any liver problems? ☐ Yes ☐ No

Have you had hepatitis or jaundice? ☐ Yes ☐ No

Do you have diarrhea ☐ or constipation ☐ ? ☐ Yes ☐ No

Do you use laxatives? ☐ Yes ☐ No

If yes, what?__________ How often __________

Do you have hemorrhoids or other rectal problems? ☐ Yes ☐ No

Have you had black or bloody stools? ☐ Yes ☐ No

When was your last sigmoidoscopic exam? __________

Have you been diagnosed as having colon polyps? ☐ Yes ☐ No

GENITOURINARY:

Have you been bothered by frequent urination? ☐ Yes ☐ No

How many times do you urinate at night? __________

Are you having burning pain while urinating? ☐ Yes ☐ No

Have you passed blood in your urine? ☐ Yes ☐ No

Have you ever had a kidney or bladder infection? ☐ Yes ☐ No

Have you ever had a kidney stone? ☐ Yes ☐ No

Do you have trouble starting or stopping the urine? ☐ Yes ☐ No

Do you sometimes lose control of your bladder? ☐ Yes ☐ No

Have you ever had a venereal disease? ☐ Yes ☐ No

If yes, what? __________

Are you having any sexual problems? ☐ Yes ☐ No

MEN:

Do you have a history of prostate trouble? ☐ Yes ☐ No

Any difficulty sustaining an erection? ☐ Yes ☐ No

Medical History (continued)

Any difficulty ejaculating? ☐ Yes ☐ No

BONES AND JOINTS:

Do you have joint pain or stiffness? ☐ Yes ☐ No

Do your joints ever get red ☐ or swollen ☐ ? ☐ Yes ☐ No

Do you have back pain that limits your activities? ☐ Yes ☐ No

Do you have severe neck pain? ☐ Yes ☐ No

Have you ever had gout? ☐ Yes ☐ No

Do you have osteoporosis? ☐ Yes ☐ No

Do you have muscle weakness ☐ or tenderness ☐ ? ☐ Yes ☐ No

Do you get muscle cramps with walking ☐ or at night ☐ ? ☐ Yes ☐ No

NEUROLOGICAL:

Are you having frequent or severe headaches? ☐ Yes ☐ No

Have you had fainting or loss of consciousness? ☐ Yes ☐ No

Have you ever had a seizure or convulsion? ☐ Yes ☐ No

Are you ever bothered by a spinning sensation or vertigo? ☐ Yes ☐ No

Do you have a balance problem? ☐ Yes ☐ No

Do you have periods of lightheadedness? ☐ Yes ☐ No

Do you have difficulty walking? ☐ Yes ☐ No

Do you experience numbness ☐ or tingling ☐ in your arms or legs? ☐ Yes ☐ No

Patient Signature:____

Reviewed by: ________________________

Date:____________________________

General Habit Questions

Name ________________________________ Date ___________ MR# ___________

Check all the following habits/pills that pertain to you now or in the recent past.

___ Tobacco ___ Sodas ___ Artificial Sweeteners

___ Caffeine ___ Diet sodas ___ Diet Pills

___ Alcohol ___ Sweets/Desserts ___ Antidepressants

___ Fruit Juices &/or Milk / Milk Substitutes (Rice Dream)

How many cups of regular coffee do you drink in a day? ___

Decaffeinated coffee? ___

How many cups of caffeinated hot tea? ___

How many cups of caffeinated iced tea? ___

On average, how many alcoholic beverages do you consume in a day? ___

If you do not drink daily, how many do you consume in a week? ___

Do you drink mostly ___ wine ___ beer ___ hard liquor?

Would you consider yourself to have a problem with alcohol? ___ Yes ___ No

How many regular sodas do you consume in a day? ___

If not daily, how many in a usual week? ___

How many diet sodas do you consume in a day? ___

If not daily, how many in an average week? ___

How many glasses of the following do you consume on an average daily basis:

Fruit Juice ____ Milk ___ Juice or Milk Substitutes ___

On average, how many sweets/desserts do you eat in a day? ____

How many items of artificial sweeteners do you use daily? ____

Please check all choices that pertain to you. Do you:

___ smoke cigarettes

If yes, how many years (include past smoking)? ___

___ number of packs a day you smoke now? In the past? ___

General Habit Questions (continued)

___ cigars How many cigars do you smoke in a day? ___ In a week? ___

___ use nicotine gum How long have you been using nicotine gum? ___

___ nicotine patches What patch do you use /for how long? ___________________

___ chew tobacco How long have you been chewing tobacco? _____________

Have you ever tried quitting any of the above and not been able to? ___ Yes ___ No

If yes, when was the last time you tried to quit? ________________________

If you are currently taking any diet pill, what are you taking? __________________________

What dose?_______________ Frequency? ______________________

Stress Questions

Would you consider yourself to be under a new acute stress? ___ Yes ___ No

If yes, please check the best description(s) of your current stress(es).

___ Family ____

___ Financial ____

___ Work Related ____

___ Personal ____

___ Illness ____

___ Travel ____

Would you consider yourself to be under constant chronic stress? ___ Yes ___ No

If yes, please check the best description of your current stress(es)?

___ Family ____

___ Financial ____

___ Work Related ____

___ Personal ____

___ Illness ____

___ Travel ____

General Habit Questions (continued)

Do you feel like you handle your stress well? ___ Yes ___ No

Do you wake up in the middle of the night thinking about things that happened during the day? ___ Yes ___ No

Do you feel that the stresses you are under are in your control? ___ Yes ___ No

How many hours do you work in day (including mothers taking care of children)? ____

How many days a week do you work? ____

How many total hours a week do you work? ____

How long do you commute to get to work? ________ Hours _______ Minutes

Do you travel extensively for your work? ___ Yes ___ No

If the definition of stress is not having enough hours in the day to take care of yourself, for example, getting enough sleep, eating correctly and on time, or having enough time for regular exercise, would you consider yourself a stressed person? ___ Yes ___ No

Stress Management

Check all the items from this list that pertain to what you do to help handle your daily stresses.

___ Exercise ____

___ Take baths/Jacuzzi____

___ Go for long walks/hikes____________________________________

___ Read ____

___ Meditate/Yoga/other forms __________________________________

___ Take regular vacations _____________________________________

___ Comfort eat ____

___ Talk with family/friends ____________________________________

___ Watch TV/movies____

___ Sleep ____

General Habit Questions (continued)

___ See a counselor ______________________________

___ Take medication ______________________________

___ Play with pets ______________________________

___ Get body work (massage, facial, etc) ______________________________

___ Drink alcohol ______________________________

Other?____

____

____

Exercise/Activity

Is your job: ___ active or ___ sedentary?

How many hours a day are you sitting down (include travel time)? ______________

On average, how much time a day do you exercise?

___ 0 min. ___ 15 min. ___ 30 min. ___ 45 min. ___ 1 hr.

___ 1 hr. 15 min. ___ 1 hr. 30 min. ___ 1 hr. 45 min. ___ 2 hrs or more

Please describe what you do for exercise/activity. Include gardening/housework/yard work, etc. ______________________________

____

____

Do you think you get enough exercise on a weekly basis? ___ Yes ___ No If no, why not? ______________________________

____

____

____

MEDICAL RELEASE FORM

Please fill-in the name of the physician, hospital or clinic you are requesting information from:

To: ____

____

____

Please forward copies of my:

o laboratory work
o diagnostic studies
o operative reports
o pertinent report(s) related to the following medical problem(s):
1.________________________
2. ________________________
3. ________________________
4. ________________________

DO NOT SEND ORIGINAL X-RAYS

Patient Name:____

Date of Birth: ______________________ Phone: ___________________

Signature:___________________________________ Date:____________________

A Note to Our Patients:
Please send this form to your physician, hospital or clinic in time for the records to arrive in our office before your appointment.
Thank you.

DIET HISTORY

Name ________________________________ Date ___________ MR# __________

Do you ever skip meals? ____ Yes ____No

If yes, how many meals on average do you skip in a week? ________

Which of the following best describes your meal plans?

____ High carbohydrate, low fat

____ A balance of carbohydrates, fats, proteins and vegetables

____ Vegetarian/Vegan

____ Mostly eating out and on the go

____ Constantly dieting

____ None of the above Please describe: ____

____

Have you ever been on a diet? ____ Yes ____ No

If yes, please list every diet, including diet pills, that you have been on. (Use back of page if needed.) ____

____

____

Are you happy about your current weight? ____ Yes ____ No

If no, why not? ____

____

Which of the following food or items do you crave?

____ Breads, pasta and other starches ____ Sweets/sugar

____ Chocolate ____ Salt ____ Alcohol

____ Other ____

Do you feel you eat enough vegetables in a day? ____ Yes ____ No

How many glasses of water do you drink in a day? ____

Food • Mood • Exercise Diary

Name ______________________ for the dates: _________ through ______________

		Breakfast	Snack	Lunch	Snack	Dinner	Exercise/Mood
Monday date ____	Time						
	Protein						
	Fat						
	Veggie						
	Carb						
	Water	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	
Tuesday date ____	Time						
	Protein						
	Fat						
	Veggie						
	Carb						
	Water	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	
Wednesday date ____	Time						
	Protein						
	Fat						
	Veggie						
	Carb						
	Water	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	

Comments About This Week:

		Breakfast	Snack	Lunch	Snack	Dinner	Exercise/Mood
Thursday ______ date	Time						
	Protein						
	Fat						
	Veggie						
	Carb						
	Water	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	
Friday ______ date	Time						
	Protein						
	Fat						
	Veggie						
	Carb						
	Water	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	
Saturday ______ date	Time						
	Protein						
	Fat						
	Veggie						
	Carb						
	Water	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	
Sunday ______ date	Time						
	Protein						
	Fat						
	Veggie						
	Carb						
	Water	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐	

MENSTRUAL HISTORY

Name:______________________________ Date:___________ MR #: ____________

1. What was your age at the time of your first period? ______________
2. Were your periods every month? Yes ____ No ____
3. Are they regular now? Yes ____ No ____
4. What was the date of your last menstrual period? ____________________
5. Have you ever had your uterus removed? Yes ____ No ____

   Ovaries removed? Yes ____ No ____

   If yes, when? _________ Why? __________________________________
6. Did you ever use birth control pills? Yes ____ No ____

   For how long? _____________ Are you on them now? Yes ____ No ____
7. Did you ever have any fertility problems? Yes ____ No ____
8. Date of last mammogram? ___________ Was it normal? ______ Abnormal? ____

   If abnormal, explain. ____

   ____
9. Other than noted above, have you ever had an abnormal mammogram?

   Yes ____ No ____ If yes, explain: ______________________________

   ____
10. Do you get routine mammograms? Yes ____ No ____

    If no, why not? ____
11. Date of last PAP smear ____________ Normal? ____ Abnormal? ____
12. Have you had a uterine ultrasound? Yes ____ No ____
13. Do you have any history of D & C's? Yes ____ No ____

    If yes, when and why? _______________________________________

MENSTRUAL HISTORY (continued)

14. Are you experiencing any of the following now?

Night sweats/hot flashes	Yes ___ No ___
Heart palpitations	Yes ___ No ___
Anxiety	Yes ___ No ___
Changes in hair/skin	Yes ___ No ___
Depression	Yes ___ No ___
Sleep disturbances	Yes ___ No ___
Emotional lability	Yes ___ No ___
Vaginal dryness	Yes ___ No ___
Decreased libido	Yes ___ No ___
Frequent headaches	Yes ___ No ___
Memory or concentration problems	Yes ___ No ___

15. How many full term pregnancies have you had? ______________________

16. How many miscarriages have you had? ____________________________

17. What was the weight of your heaviest baby? _________________________

18. What was your weight before and after each pregnancy? ______________

19. Were you able to lose the weight after each pregnancy without dieting?

    Yes ____ No ____

20. Did your periods resume normally after each pregnancy? Yes ____ No ____

21. Have you had a bone mineral density study? Yes ____ No ____

    If yes, when? ____________ Results? ______________________

Menstrual Cycle Calendar for ________
year

Please use these symbols in the boxes above the dates:

Name ______________________________

MR#________________________________

Spotting	Light Flow	Normal	Heavy	Very Heavy
	3-4 hours	2-3 hours	1-2 hours	every hour > call us

Please Bracket Your Progesterone Cycle

Month																															
January	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
February	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29 Leap Year		
March	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
April	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
May	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
June	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
July	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
August	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
September	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
October	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
November	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	
December	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31