Medical History

PLEASE COMPLETE ALL PAGES

Name:____Date:_________________DOB:________________

Please be as specific as possible as this form will give us a better understanding of your medical concerns and conditions. If you are uncomfortable with any questions, do not answer them. Please contact family members if you need assistance in completing the Family History section. You may attach additional pages as necessary.

THANK YOU!

How would you rate your current health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current age:____________ Weight:______________ Height:_______________ Ethnicity:__________________

Waist Measurement:_________________________ Date of Last Physician Exam:________________________

Medications: Prescription and Non-prescription medications, vitamins, home remedies, birth control pills, herbs.

Medication: Dose (eg. Mg/pill) How many times/day When Started Why Using

____

____

____

____

____

____

____

____

Allergies or Adverse Reactions to Medicines:____

____

Date of most recent screening for the following:

Cholesterol_____________________ Chest X-Ray _____________________ EKG ________________

Spirometry_____________________ Bone Density_____________________

Any other VASCULAR TEST____

Personal Medical History:

Please indicate whether you have had any of the following medical problems (with dates):

☐ Heart Disease_______

☐ Bleeding/Clotting Problems________

☐ Alcoholism *specify type* _________

☐ Rheumatoid Arthritis _________

☐ Gout __________

☐ Aortic Aneurysm ________

☐ High Blood Pressure _______

☐ Blood Transfusion ________

☐ Polycystic Ovaries ________

☐ High Cholesterol _______

☐ Poor Blood Flow to Extremities __________

☐ Cancer (*Malignancy*) _________

☐ Diabetes *specify type* _________

☐ Thyroid Problems _________

☐ Depression / Suicide Attempts _________

☐ Unexplained Nerve Problems *specific types* _________

☐ Lupus __________

☐ Psoriasis __________

☐ Migraine Headaches _____________
☐ With Aura ☐ Without Aura

☐ Fatty Liver __________

☐ Pre-diabetes _________

☐ Chronic Dental Problems _________

☐ Osteoporosis _______________

☐ Autoimmune Disorder_______________

☐ H. Pylori Infection _______________

☐ Other

Have you ever had the following procedures? If so, please list the dates:

☐ Coronary Artery Bypass Surgery_______________

☐ Angioplasty or Stent_______________ ☐ Angiogram_______________

Have you ever been hospitalized for illness? ☐ Yes ☐ No If so, list when and reason:

____

____

Surgical History: Please list all other operations (with dates)

____

____

____

Social History:

Tobacco use: Cigarettes ☐ Never ☐ Quit: Date: ____________ Pack/Years ____

☐Current Smoker: Pack/ day________ Other Tobacco ☐ Pipe ☐ Cigar ☐Chew # of years______________

Are you interested in quitting? ☐ No ☐ Yes Second-hand smoke exposure? ☐ No ☐ Yes

Alcohol use: Do you drink alcohol ☐ No ☐ Yes # of drinks/week______________________________

Is alcohol a concern for you or others? ☐ No ☐ Yes

Sexual History:

Male do you have a problems with erections? ☐ No ☐ Yes Date of Onset:___________________

Female: Birth Control Method: _______________________________________ None Needed_______________

#of pregnancies _____________ #of deliveries_______________ #of miscarriages_______________

Problems with pregnancy or deliveries?________ Osteoporosis_______________ Osteopenia___________

Any history of gestational diabetes? ☐ No ☐ Yes Eclampsia? ☐ No ☐ Yes

Children: Weighing Over 10 lbs. at birth? ☐ No ☐ Yes

____

1st day of most recent period:___________ Age at 1st period:____ Frequency:____________

Length of each:________

Other Concerns

Caffeine Intake: ☐ None ☐ Coffee/Tea_______ cups/day ☐ Sodas___day ☐ Chocolate _____oz/day

Weight: Are you satisfied with your weight? ☐ No ☐ Yes

Diet: How do you rate your diet? ☐ Good ☐ Fair ☐ Poor

Do you take supplements? ☐ No ☐ Yes(if so, what kind?)____________________________________

Do you drink 4 large glasses of milk daily or take calcium supplements? ☐ No ☐ Yes

Exercise Do you exercise regularly? ☐ No ☐ Yes

What kind of exercise?____

How long? Minutes?____

How often?_________________

If you don't exercise, why?____

Socioeconomics:

Occupation:__________________________________ Employee:__________________________________

Years of Education/Highest Degree:____________________ Marital Status ☐ S ☐ M ☐ D ☐ W

Spouse/partner's name:_________________ Who lives at home with you?_________________

Number of Children:_____ Ages:________ _________ ___________ ___________ _________ ___________

How would you classify the stress at work? ☐ Minimal ☐ Medium ☐ High

How would classify the stress at home? ☐ Minimal ☐ Medium ☐ High

Do you feel anxious, angry, irritated or rushed? ☐ No ☐ Yes

Nutrition: How many daily servings of the following do you have?

________Whole grains ________Fruits ________Vegetables

How many times in one week do you consume the following items?

____Eggs ____Fish ____Chicken/Turkey ____Red Meat ____Butter ____Margarine

____Other high fat dairy products ____Other low fat dairy products ____Fried Foods

____High fat snacks What type of cooking oil do you use?____________________

Review of Symptoms: Please Check ( ) any current problems you have on the list below:

Constitutional :

☐ Fever/Chills/Sweats ☐ Change in skin texture ☐ Change in hair texture

☐ Unexplained weight loss/gain ☐ Inability to stand heat ☐ Change in energy / weakness

☐ Brittle nails ☐ Inability to stand cold ☐ Excessive thirst or urination ☐ Dry skin

Respiratory:

☐ Cough/Wheeze ☐ Difficulty Breathing ☐ Snoring

☐ Eyes: Change in vision ☐ Ears/Nose/Throat/Mouth: ☐ Difficulty hearing/ringing in ears

☐ Problems with teeth/gums ☐ Hay fever / Allergies ☐ Growth in throat / neck

Cardiovascular:

☐ Chest pain / discomfort ☐ Palpitations

Chest:(Breast)

☐ Breast lump / nipple discharge

Skin:

☐ Rash/mole change ☐ Acanthosis nigricans

Geuitonrinary:

☐ Unusual frequency of urination

Sexual:

☐ Problems with erectile function

Gastrointestinal:

☐ Abdominal pain ☐ Diarrhea / constipation ☐ Blood in bowel movement

☐ Heartburn ☐ Nausea/Vomiting

Neurological:

☐ Headaches ☐ Loss of coordination ☐ Light-headedness

☐ Tingling/Pain/Numbness in hand or feed ☐ Memory loss

Psychiatric:

☐ Problems with sleep ☐ Depression

☐ Panic attacks ☐ Mania

Blood/Lymphatic:

☐ Easy bruising/bleeding ☐ Unexplained lumps

Any other symptoms? If yes, please explain:____

____

Family History

Please indicate the current status of your immediate family members:

	Alive	Deceased	Age (present or at death)	Comments/Cause of death
Mother's Mother				
Mother's Father				
Father's Mother				
Father's Father				
Father				
Mother				
Sister				
Sister				
Sister				
Brother				
Brother				
Brother				
Daughter				
Daughter				
Daughter				
Son				
Son				
Son				

Please use this space to add any additional family members:

Family History

Please indicate with a (check) family members who have had any of the following:

Medical Condition	Mom	Dad	Sis.	Bro.	Dghtr	Son	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Mom's Sis	Mom's Bro	Dad's Sis	Dad's Bro
Alcoholism														
Anemia														
Aortic Aneurysm														
Alzheimer's														
Arthritis														
Asthma														
Autoimmune disorder														
Bleeding problems														
Carotid artery disease														
Carotid artery disease														
Cancer														
Gout														
Heart attack														
Depression														
Diabetes-Type 1 (Childhood Onset)														
Diabetes-Type 2 (Adult Onset)														
Other genetic disease														
High Cholesterol (hyperlipidemia)														
High blood pressure (hypertension)														
Immunosuppressive disorders														
Kidney disease														
Osteoporosis														
Peripheral vascular disease														
Epilepsy (seizure disorder)														
Stroke														
Substance Abuse														
Thyroid disorder														
Smoking														
Sleep Apnea														

Demographics Form

Please Print

Name:____ ☐ Male ☐ Female
First Middle Last

Address:________________________ City:______________ State:___________ Zip:_____________

D.O.B:___/___/______ Age:____________ Social Security#:_____-_____-_______ Marital Status: S M D W
circle

Home Phone: (____) __________________ Email Address:__________________________

Cell Phone: (____) ____________________ Other Phone: (____) ______________________

Employer__________________________ Work Phone: (____) ______________________

Emergency Contact (Friend / Relative):______________________Phone: (____) ____________________

Parent / Spouse Name:____
First Middle Last

Insurance Co.: __________________________ ID#:________________________ Group#:_____________

Subscriber's Name:_________________________________ Subscriber's Date of Birth:____/___/_______

Person responsible for the bill?: ☐ Self ☐ Spouse ☐ Other__________________

Name (if different from above):____

How did you hear about our center? ____

____

____

____

____

Patient's Signature:_________________________________ Date:__________________