Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_ Sex: M F

Are you: Married Single Divorced Widowed Separated

How did you hear about our center? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did you have your last health care visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was the reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list, in order of importance, your health problems:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History** Y = yes N = no P = past

Has any family member had the following: If yes, please identify family member:

Anemia Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asthma Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Epilepsy Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High Blood Pressure Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Disease Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Illness Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pneumonia Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuberculosis Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Venereal Disease Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were any of these a cause of death? If so, which family member and at what age? \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunizations**

Polio Y N Diphtheria Y N Rubella Y N

Measles/Mumps Y N Pertussis Y N Hepatitis B Y N

Pneumonia Y N Small Pox Y N Anthrax Y N

Tetanus Y N Date of last tetanus shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Childhood Illnesses**

Scarlet Fever Y N Diphtheria Y N Rheumatic Fever Y N

Mumps Y N Measles Y N German Measles Y N

**Allergies**

What are you allergic to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Environmental Allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized? Y N If yes, when and for what reason? \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any surgeries? Y N If yes, when and for what reason? \_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications**

Appetite Suppressants Y N Laxatives Y N

Tobacco Y N Antacids Y N

Pain Relievers Y N Tranquilizers Y N

Birth Control Pills Y N Sleeping Pills Y N

Thyroid Y N Cortisone Y N

Please list any prescription medications, over-the-counter medicines, vitamins or other supplements you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Environmental**

Have you often had to lower the regular dose of prescription, over-the-counter medication or herbal supplements because you were too sensitive to normal doses? Y N P

Do you avoid caffeine in the afternoon or all together because it can keep you up at night? Y N P

Have you ever experienced adverse reactions to medications? If so, what happened?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smell odors when others can’t? What kind of odors?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a sudden onset of symptoms (headaches, skin rashes, nausea, fatigue, shortness of breath, etc.) on exposure to chemicals, mold, dust, pollens, or other environmental allergens? What symptoms?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all the chemicals that you have adverse reactions to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin**

Acne Y N P Boils Y N P

Color Changes Y N P Eczema Y N P

Hives Y N P Itching Y N P

Rash Y N P Moles Y N P

Lumps Y N P Scaling Y N P

**Head**

Hair loss Y N P Headaches Y N P

Head Injury Y N P Skull fracture Y N P

**Eyes**

Eye Pain Y N P Cataracts Y N P

Double vision Y N P Dryness Y N P

Vision aids Y N P Glaucoma Y N P

Impaired vision Y N P Tearing Y N P

**Ears**

Discharge Y N P Earaches Y N P

Dizziness Y N P Impaired hearing Y N P

Ringing Y N P Trauma to ear Y N P

**Nose & Sinuses**

Frequent Colds Y N P Hay fever Y N P

Nose Bleeds Y N P Sinus pain Y N P

Stuffiness Y N P Persistent running Y N P

Trauma Y N P Polyps Y N P

**Mouth & Throat**

Bleeding gums Y N P Difficulty swallowing Y N P

Cavities Y N P Frequent sore throat Y N P

Hoarseness Y N P Sore tongue Y N P

Ulcerations Y N P Difficulty speaking Y N P

**Neck**

Goiter Y N P Lumps Y N P

Pain or Stiffness Y N P Swollen Glands Y N P

Trauma to Neck Y N P Thyroid Medication Y N P

**Respiratory**

Asthma Y N P Bronchitis Y N P

Cough Y N P Emphysema Y N P

Pneumonia Y N P Difficulty Breathing Y N P

Pleurisy Y N P Pain with Breathing Y N P

Sputum Y N P Shortness of Breath Y N P

Tuberculosis Y N P with lying down Y N P

Wheezing Y N P with exertion Y N P

Blood in Sputum Y N P at night Y N P

**Cardiovascular**

Angina Y N P Chest Pain Y N P

High blood pressure Y N P Dizziness Y N P

Heart disease Y N P Murmur Y N P

Palpitations/flutter Y N P Leg pain with walking Y N P

Rheumatic fever Y N P Ankle swelling Y N P

**Gastrointestinal**

Belching Y N P Blood in stool Y N P

Change in appetite Y N P Change in thirst Y N P

Gall bladder disease Y N P Heartburn Y N P

Gas/Bloating Y N P Hemorrhoids Y N P

Liver disease Y N P Jaundice/yellow skin Y N P

Vomiting Y N P Bowel Movements:

Ulcers Y N P How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Is this a change? Y N

**Urinary**

Frequent infections Y N P Frequency at night Y N P

Increased frequency Y N P Unable to hold urine Y N P

Kidney stones Y N P Kidney Pain Y N P

Pain with urination Y N P Urethral discharge Y N P

**Endocrine/Blood**

Anemia Y N P Excessive thirst Y N P

Easy to bleed/bruise Y N P Heat/cold intolerance Y N P

Excessive hunger Y N P Low energy/fatigue Y N P

**Female Reproductive System**

Age menses began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Control Y N P

Average number of days: \_\_\_\_\_\_\_\_\_\_\_ what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of cycle: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of pregnancies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are cycles regular? Y N P Number of live births: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have: Number of miscarriages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Painful menses Y N P Number of abortions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain with intercourse Y N P Difficulty conceiving Y N P

Excessive flow Y N P Menopause symptoms Y N P

PMS Y N P History of venereal disease Y N P

Sexual difficulties Y N P Are you sexually active Y N P

**Breasts**

Do you do self exams Y N P Nipple discharge Y N P

Lumps Y N P Skin discoloration Y N P

Breast Pain Y N P

**Male Reproductive System**

Hernia Y N P Are you sexually active Y N P

Testicular pain Y N P Sexual difficulties Y N P

Testicular masses Y N P Prostate disease/pain Y N P

Discharges or sores Y N P Venereal disease Y N P

**Musculoskeletal**

Joint pain/stiffness Y N P Broken bones Y N P

Swelling of joints Y N P Muscle cramps Y N P

Arthritis Y N P Weakness Y N P

**Peripheral Vascular**

Cold hands/feet Y N P Varicose veins Y N P

Deep leg pain Y N P Spider veins Y N P

Numbness hands/feet Y N P Thrombophlebitis Y N P

**Neurological**

Dizziness Y N P Numbness/tingling Y N P

Fainting Y N P Memory loss Y N P

Seizures Y N P Paralysis Y N P

**Mental/Emotional**

Anxiety/nervousness Y N P Excessive fears Y N P

Depression Y N P Mood swings Y N P

Excessive anger Y N P Tension/stress Y N P

**Habits**

Do you wake rested Y N P What are your main hobbies and interests?

Sleep Well Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Average hours of sleep: \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enjoy your work Y N P What forms of exercise do you get?

Watch television Y N P \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours/day: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work at a computer Y N P Exercise how often?

How many hours/day: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Read Y N P Have you been treated for:

How many hours/day: \_\_\_\_\_\_\_\_\_\_\_\_\_ alcohol dependence Y N P

Take vacations Y N P drug dependence Y N P

Do you use:

 Recreational drugs Y N P

 Alcoholic beverages Y N P

**Infants and Children**

Does your child:

Sleep through the night Y N P Eat well Y N P

Frequent sore throats Y N P Frequent earaches Y N P

Constipation Y N P Diarrhea Y N P

Hyperactive Y N P Colic Y N P

Constant runny nose Y N P Lethargic Y N P

Abnormal weight gain/loss Y N P Irritable Y N P

Behavioral problems Y N P Skin rashes Y N P

Reaction to vaccines Y N P