ANDREA DEMPSEY M.D.
Board Certified Internal Medicine

HEALTH HISTORY

Date: _____

NAME:_____ **Birth date:** ___/____/____ **Age:** _____

Marital Status: _____ **Level of Education**: _____

Current Occupation: _____ **Are you here for hormone replacement?** *Y / N*
Is it stressful? *Y / N* Is it fulfilling? *Y / N* Work related hazardous material exposure? *Y / N*

YOUR GOALS/REASON FOR VISIT:

_____

Previous Primary Doctor:_____
Specialists:_____
_____

PLEASE LIST ACTIVE MEDICAL PROBLEMS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

PRESCRIPTION & OVER the COUNTER medications you are currently taking:

_____
_____
_____
_____
_____
_____

ALLERGIES: - DRUGS: FOODS:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

NUTRIENTS / SUPPLEMENTS you are taking:

_____
_____
_____
_____

Hormone Therapies:_____
_____

CONDITIONS:

Check <u>any other</u> conditions you have ever had in the past, & indicate what year?

___ AIDS / HIV+	___ Allergies / Asthma	___ Anemia	___ Alcohol / drug problem
___ Anorexia / Bulimia	___ Arthritis	___ Atrial Fibrillation	___ Anxiety / Panic Disorder
___ Back pain	___ Bleeding Disorder	___ Candida / Yeast	___ Cancer – Specify: _____
___ Chronic Fatigue	___ Crohn's Disease	___ Colitis	___ Diabetes -Type: I II
___ Depression	___ Emphysema	___ Epilepsy / Seizures	___ Fibromyalgia
___ Glaucoma	___ Goiter	___ Gout	___ Hiatal Hernia / Reflux
___ Heart Disease	___ High cholesterol	___ Irritable Bowel	___ Hypertension / High BP
___ Jaundice	___ Kidney Disorder	___ Kidney Stones	___ Liver Disease
___ Hepatitis	___ Migraines	___ Multiple Sclerosis	___ Osteoporosis
___ Pancreatitis	___ Parasites	___ Parkinson's	___ Pelvic Infl Disease
___ Pneumonia	___ Polio	___ Prostate Problem	___ Rheumatic Fever
___ Root canal	___ Sinusitis	___ Stroke / TIA	___ Suicide Attempt
___ Thyroid problem	___ TMJ	___ Tooth Abscess	___ Tuberculosis
___ Ulcers	___ Urinary Infection	OTHER: _____	

CURRENT or RECENT SYMPTOMS: *Check any symptoms that you have noticed recently.*

___ Chest pain
___ Nose bleeds
___ Abdominal Pain
___ Difficulty swallowing
___ Kidney pain
___ Change in headaches
___ Bone pain
___ Excessive thirst
___ Recent change in bowel habit
___ Weight loss - unexpected
___ Blood in sputum
___ Shortness of Breath
___ Acid reflux
___ Loss of appetite
___ Blood in urine
___ Double vision
___ Unusual bruising
___ Rapid heart beat
___ Fainting / collapse
___ Swollen ankles
___ Black tarry stools
___ Persistent nausea
___ Frequency of urination
___ Dizzy / spinning
___ Prolonged bleeding
___ Leg pain w walking
___ Snoring excessively
___ Bright blood in stool
___ Mood swings
___ Urgency of urination
___ Eye pain
___ Bloated
Other Symptoms:_____
_____
_____

HOSPITALIZATIONS: *Please include Surgeries, illnesses, severe accidents, births, miscarriages:*

Year:	Procedure	Reason:	Outcome:

FAMILY HISTORY: *Please complete health Information about your family:*

Relation	Age:	State of health:	Age at Death:	Cause of death	Check if your blood relatives had any of the following √	Disease:	Relation to you:
Father						Arthritis / Gout	
Mother						Asthma / Hay Fever	
Brothers						Cancer: Where: _____	
						Drugs / Alcohol	
						Diabetes	
						Heart Disease	
Sisters						High Blood Pressure	
						Osteoporosis	
						Stroke	
						Tuberculosis	

RECENT TESTS:
If you have had any of these tests, please complete:

TEST:	Date	Reason:	Result:
Chest X Ray			
EKG			
EGD (Stomach)			
Colonoscopy			
Ultrasound			
CAT Scan			
MRI Scan			
Bone Density			
Blood tests			

HEALTH HABITS:
***Which substances do you consume*:**

Substance	How Much?	
Caffeine	cups,cans / day	
Cigarettes	packs / day	
Are you interested in quitting? Y / N		
Alcohol Y N	Type: Amount	
Drugs Y N	Type: Amount	
Chew tobacco Y N	Amount Yrs	
Hx of Substance Abuse Y N	Years Abstinent:	

FOR WOMEN:

Date of 1st day of last period: _____ Birth control method: _____ Are you pregnant? Y / N
Date of last Pap test: _____ *normal / abnormal* Date of last Mammogram: _____ normal */ abnormal*
Are you currently on Hormone Replacement therapy? Y / N Have you had a Breast Biopsy? Normal / Abnormal
Date of Menopause: _____ Have you ever had an abnormal pap? Y / N When? _____
Review this list of symptoms and check the ones that apply.

___ PMS	___ Hot flashes	___ Sleep problems
___ Uterine Fibroid	___ Vaginal Dryness / Pain	___ Mood swings
___ Fibro-cystic Breasts	___ Loss of interest in sex	___ Painful Periods
___ Ovarian Cysts	___ Leak Urine	___ Unusual vaginal discharge
___ Irregular periods	___ Painful periods	___ Cramps / clots w periods
___ Vaginal irritation	___ Painful sex	___ Spotting after menopause
___ Increased fat around hips / thighs	___ Endometriosis	___ Problems w Infertility

FOR MEN:

Date of last prostate exam: _____ *normal / abnormal*
Review this list of symptoms and check the ones that apply:
.___ Lowered interest in sex __ Erections less firm___ Difficulty in initiating urine stream __ Getting up at night to urinate ___ Enlarged prostate __ Can't maintain an erection__ Slowing urinary stream___ Problems w Infertility __ Bladder not emptying completely

DIET: Are you on any specific diet? *(Please specify:*_____ Successful? Y / N
List which diets have been effective in the past: _____

STRESS:

Rate your current stress level: *Extreme; High; Medium; Low (Please circle)*
How long has it been like this? _____
You expect this to last a *short medium long* period of time. *(please circle)*
Do you have a solution? Y / N
Do you need help? Y / N

EXERCISE: ***Please circle which you do.***

Aerobic Weights Walking Other: _____
How long are your workout sessions? _____ How many days per week? _____

SLEEP: *Please check the symptoms that you notice.*

___ Trouble getting to sleep – racing mind
___ Sleep not as restful / Wake up not rested
___ Wake up through night feeling like you are choking or having a smothered sensation
___ Your partner has noticed very heavy snoring during sleep
___ Your partner has noticed that you stop breathing through the night with heavy snoring
___ Daytime drowsiness or sleepiness especially with periods of inactivity
___ Toss and turn through night / wake frequently through night

Take a moment to reflect on your response to the following question:
On a scale of 0 – 5 (5 being the strongest response), circle your response:

How important and committed are you to improving your current health? 0 1 2 3 4 5

Patient Signature:_____ Date:_____

***ONLY** COMPLETE THE FOLLOWING SECTION IF YOU ARE INTERESTED IN HRT –*

Hormone Replacement Therapy

Thyroid:

___ Dry hair
___ Infertility
___ Migraines
___ Losing hair
___ Constipation
___ Fluid retention
___ Crave caffeine
___ Dry coarse skin
___ Diets don't work
___ Cold hands & feet
___ Elevated cholesterol
___ Low body temperature
___ Fatigue / Exhaustion
___ Decreased memory
___ Brittle unhealthy nails
___ Unable to lose weight
___ Daytime drowsiness
___ Foggy / spacey mind
___ Depression / Anxiety
___ Low ambition / motivation
___ Decreased concentration
___ Fibromyalgia / Chronic fatigue
___ Feel cold / dress more warmly

Cardio-Respiratory:

___ Palpitations
___ Decreased stamina
___ Decreased endurance
___ Run out of breath sooner
___ Easily exhausted with exercise
___ Decreased ability and desire for exercise

Skin / Integumentary:

___ Dry skin
___ Thin Lips
___ Graying hair
___ Skin blemishes
___ Thin brittle nails
___ Tendency to bruising
___ Thinned skin –hands, face, arms
___ Thinning hair – scalp, armpits, legs
___ Wrinkling skin – face, neck, hands & arms
___ Sagging skin – under eyes, arms, face, breasts

Gastrointestinal:

___ Feel full faster
___ Slower digestion
___ Fullness after meals
___ Eat less / smaller meals
___ Indigestion / Hyperacidity
___ Burping or belching after meals
___ Decreased sense of taste / smell

Adrenal:

___ Palpitations
___ Salt craving
___ Sugar craving
___ Panic attacks
___ Muscle tension
___ Easily frustrated
___ Excessive hunger
___ Prone to infection
___ Low blood pressure
___ Poor stress tolerance
___ Low back pain (SI joints)
___ Light headed on standing up
___ Racing mind prevents sleep
___ Need sunglasses in bright sun light

Metabolism:

___ Can not skip meals
___ High blood pressure
___ Headache w missed meal
___ Cravings for sugar & carbs
___ High cholesterol / triglyceride
___ Increased fat around abdomen
___ Prone to inflammation and bursitis
___ Periods of low energy relieved w food
___ Shaky / weak episodes – Eating helps
___ Jittery / irritable episodes – Eating helps
___ Alternating between high and low moods
___ Alternating between sluggish and high energy

Neuro-cognitive:

___ Loss of esteem
___ Feeling hopeless
___ Feeling defeated
___ Loss of confidence
___ Vision deteriorating
___ Hearing deteriorating
___ Memory deteriorating
___ Sense of powerlessness
___ Decreased sense of well being

Muscles/Joints:

___ Osteoporosis
___ Aches and Pains
___ Loss of strength
___ Body & joints stiff
___ Balance deteriorating
___ Coordination deteriorating
___ Thinning muscles – buttocks, arms, legs

Patient Signature:_____ Date:_____