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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:_____