

PERSONAL MEDICAL HISTORY

Name & date of birth _____ Today's date _____

ALLERGIES to medicine: _____ REACTION (what happened when you took the medicine?): _____

Part 1. Personal and family medical history: Have you, or a close relative, had any of these?

problem:	i had it - at what age - details:	family member/s had it - age - details:
___ high blood pressure		
___ high cholesterol		
___ heart trouble/ heart attack		
___ stroke/ mini-stroke		
___ breast cancer		
___ hysterectomy		
___ cancer of ovary		
___ prostate cancer		
___ colon cancer		
___ diabetes		
___ depression		
___ osteoporosis, or broken hip/shoulder		
___ other (what?)		

Do you have any concerns about health problems that might run in your family? What are they?

Have you ever been in the hospital (overnight, not emergency room)?

Please give approximate dates, reason for hospitalization, and outcome:

For women only:

Age menstruation started:

Age menopause started:

Number of times you have gotten pregnant:

Number of times you have had a baby:

Any current menstrual or fertility problems you'd like help with? What are they?

Any current sexual problems you'd like help with? What are they?

If heterosexually active, how do you keep from getting pregnant?

How do you prevent sexually transmitted infections?

Have you had any of the following risk factors for blood-borne viruses:

- used IV drugs? had a sexual partner who used them?
- got blood transfusions? had a sexual partner who did?
- been in prison? had a sexual partner who has been in prison?

For men only:

Any current sexual or fertility problems you'd like help with? What are they?

If heterosexually active, how do you prevent pregnancy?

How do you prevent sexually transmitted infections?

Have you had any of the following risk factors for blood-borne viruses:

- used IV drugs? had a sexual partner who used them?
- got blood transfusions? had a sexual partner who did?
- been in prison? had a sexual partner who has been in prison?

For patients who are children only (for parents to fill out):

Birth weight: _____ considered preterm _____ full-term, but small-for-dates

Method of birth: _____ normal (vaginal) _____ born by planned cesarean _____ born by emergency cesarean

(_____ No problems during pregnancy, birth, or while newborn)

Problems during pregnancy: _____

Problems during birth: _____

Problems when newly born (needed special care?): _____

Any other hospitalizations or surgeries? _____

Details:

Infant feeding: _____ breast milk only (how long?) _____

_____ formula fed (what kind?) _____

_____ breastmilk and formula (how long?) _____

Any special diet at this time: _____

Receiving vaccinations on the usual schedule? _____

Is child in day care or school? _____ How many hours a day _____ How many days a week _____

Who lives at home with the child?

Any pets in the home? _____ What kind: _____

Any guns in the home? _____ How are they stored: _____

Any long-term or repeated health problems?

Any long-term or repeated behavior/emotional problems?

Any concerns about growth or development?

Any concerns about your child's safety or well-being?

Part 2. Social History - these answers, which are strictly confidential, have an impact on your health.

Where did you grow up?

How far did you go in school (junior year of high school, some college, PhD, etc)?

Do you work at a job? If so, what is it?

Do you currently have any legal problems?

Who lives at home with you?

Who is your biggest source of emotional support (who is really "there for you")?

Is there anyone in your life who fights with you a lot?
If so, how do you handle this?

Do you have a regular exercise program? If so, what is it?

Do you have a regular spiritual practice? If so, what is it?

About how many packs of cigarettes do you smoke in a week?

About how many drinks (beers, wine or coolers, shots, cocktails, etc) do you have in a week?

Do you use recreational drugs? If so, what?

Have you ever been in a recovery program to become clean or sober? If so, when?

When you drive, do you wear a seatbelt? ___sometimes ___always ___not usually ___it depends

When you ride a bike or motorcycle, do you wear a helmet? ___sometimes ___always ___don't own one

Does your home have smoke detectors that are currently working (with good batteries)?

Do you have any pets?_____ If so, what pets?

Do you own any guns?_____ If so, how are they stored?

Part 3. Current health issues

What other health care providers do you see regularly?

- chiropractor personal trainer/fitness instructor
 massage therapist psychologist/counselor/therapist
 energy worker dentist/oral surgeon
 medical specialist/s (cancer doctor, heart doctor, endocrinologist, etc.) - please explain:

other/s - please explain:

Please check off, if any of these are a problem you currently want medical help for:

Head, eyes, ears, nose, and throat:

- (these are not medical problems for me right now)
 Headaches
 Problems with eyesight
 Eye pain
 Eyelid problems
 Ear pain
 Ringing/buzzing/humming/hissing/roaring in ears
 Can't hear as well as you used to
 Voice problems
 Problems chewing or swallowing

Heart, lungs, blood vessels:

- (these are not medical problems for me right now)
 Difficulty breathing
 Cough
 Chest pain
 Heart pounding or palpitations
 Fainting or almost fainting
 Leg pain when you are walking
 Restless or cramping legs during sleep
 Leg swelling

Belly:

- (these are not medical problems for me right now)
 Heartburn, acid reflux, burping, nausea, or gas
 Stomach pain
 Diarrhea (loose, liquid stools)
 Constipation (hard, painful stools)
 Rectal pain
 Blood in the stool, in the toilet, or on the paper
 Bowel movements that are unusual for you

Urinary and genital area:

- (these are not medical problems for me right now)
 Frequent or urgent need to pee
 Accidentally leaking pee
 Difficulty starting to pee, or a weak stream
 Pain or burning when you pee
 Difficulty getting sexually aroused
 Difficulty with erection
 Pain during sex
 Feeling upset, scared, or angry about sex
 Unusual discharge from your genitals
 Itching or burning of your genitals
 Birth control issues

Breast:

- (these are not medical problems for me right now)
 Lump
 Pain
 Discharge from nipple
 Uneven size or shape

Skin, nails, hair:

- (these are not medical problems for me right now)
 Itchy or painful skin rash
 Acne
 Unusual-looking spot on skin
 Concern about a black, weird-looking, or itchy mole
 Lump on or under skin
 Problems with fingernails or toenails
 Hair falling out
 Scalp problem

Bones, muscles, nerves:

- (these are not medical problems for me right now)
 Weak muscles, or getting tired easily
 Joint pain
 Joint stiffness, redness, or puffiness
 Fingers go numb and change color when cold
 I have gout or rheumatoid arthritis
 I have a connective tissue disease (lupus, etc)
 Back pain
 Neck pain
 Pain all over, with flareups
 Numbness
 Vertigo (the room is spinning)
 Dizziness (like you'll lose your balance)

Psyche:

- (these are not medical problems for me right now)
 Can't sleep
 Not enjoying life anymore
 Feeling guilty or hopeless
 Grieving
 Repeated thoughts of death
 Feeling irritable and angry
 Hearing voices talking, when nobody is there
 Can't stop worrying
 Panic attacks or flashbacks
 Fighting with loved ones
 Losing your memory

