

Superstition Vitality Center, LLC

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What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Past Medical History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Abnormal Pap Smear |  | Drug Abuse |  | Osteoporosis |
|  | Acne |  | Eating Disorder |  | Positive TB Skin Test |
|  | ADD/ADHD |  | Eczema |  | Prostate Problems |
|  | Alcohol Abuse |  | Emphysema |  | Psoriasis |
|  | Anemia |  | Frequent UTI’s |  | Reflux (Heartburn) |
|  | Anxiety |  | Frequent Sinus Infections |  | Rheumatoid Arthritits |
|  | Asthma |  | Gallstones |  | Seasonal Allergies |
|  | Bipolar Disorder |  | Gout |  | Seizures |
|  | Blood Clots |  | Heart Attack |  | STD’s |
|  | Blood Transfusion |  | Heart Condition |  | Stomach Ulcers |
|  | Cancer |  | High Blood Pressure |  | Stroke |
|  | Chronic Bronchitis |  | High Cholesterol |  | Tuberculosis |
|  | Crohn’s or IBS |  | Kidney Disease |  | Thyroid (Hyper/Hypo) |
|  | Depression |  | Kidney Infections |  | Ulcerative Colitis |
|  | Diabetes |  | Kidney Stones |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Diverticulitis |  | Lupus |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Surgical History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Type of Surgery | Year |  | Type of Surgery | Year |
|  | Appendectomy |  |  | Implants |  |
|  | Arthroscopy (Joint) |  |  | Knee or Hip Replacement |  |
|  | Back or Neck Surgery |  |  | Mastectomy or Lumpectomy |  |
|  | Cataract Surgery |  |  | Polyp Removal (Colon) |  |
|  | Cesarean Section |  |  | Tonsillectomy/Adenoidectomy |  |
|  | Gallbladder Removal |  |  | Tubal Ligation or Vasectomy |  |
|  | Heart Surgery |  |  | Plastic Surgery |  |
|  | Hemorrhoids |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | Hernia |  |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | Hysterectomy |  |  |  |  |

Other medical problems not on list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Allergies** to medications, food, or latex and reactions (nausea, hives, etc.)

 [ ]  No Known Allergies to Medication

|  |  |  |
| --- | --- | --- |
| **Name of Allergen** | **Reaction** | **Date** |
|  |  |  |
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**Current Medications** (include vitamins, calcium, herbs over the counter meds).

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| --- | --- | --- | --- | --- |
| **Name of Medication** | **Dose** | **Frequency** | **Started** | **Reason** |
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**Family History**

 Father Mother Grandparent Other Father Mother Grandparent Other

Alcoholism [ ]  [ ]  [ ]  [ ]  High Cholesterol [ ]  [ ]  [ ]   [ ]

Asthma [ ]  [ ]  [ ]  [ ]  Kidney Disease [ ]  [ ]  [ ]  [ ]

Bleeding Disorder [ ]  [ ]  [ ]  [ ]  Mental Illness [ ]  [ ]  [ ]  [ ]

Cancer [ ]  [ ]  [ ]  [ ]  Migraine [ ]  [ ]  [ ]  [ ]

Diabetes [ ]  [ ]  [ ]  [ ]  Osteoporosis [ ]  [ ]  [ ]  [ ]

Epilepsy/Convulsions [ ]  [ ]  [ ]  [ ]  Stroke [ ]  [ ]  [ ]  [ ]

Heart Disease [ ]  [ ]  [ ]  [ ]  Thyroid Disease [ ]  [ ]  [ ]  [ ]

High Blood Pressure [ ]  [ ]  [ ]  [ ]  Other [ ]  [ ]  [ ]  [ ]

Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Current Smoker:  **Yes** or **No** Number of Years**:** \_\_\_\_\_\_Packs per Day: \_\_\_\_\_\_

Former Smoker:  **Yes** or **No** Number of Years**:** \_\_\_\_\_\_Packs per Day: \_\_\_\_\_\_

Electronic Cigarette/Vape: **Yes** or **No** Medical Marijuana: **Yes** or **No**

Chew Tobacco: **Yes** or **No**

Do you drink alcohol? **Yes** or **No** [ ]  Liquor [ ]  Beer [ ]  Wine How often? [ ]  Daily [ ]  Weekly[ ]  Socially

Recreational Drugs: **Yes or No** If yes, which ones? **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Last Dental Exam: ­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunizations**

Last Flu Vaccine: \_\_\_\_\_\_\_\_\_\_\_ Last Pneumococcal Vaccine: \_\_\_\_\_\_\_\_\_\_\_ Last Tetanus: \_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Abdominal Pain |  | Shortness of Breath |  | Sore Throat |
|  | Headaches |  | Chest Pain |  | Nausea/Vomiting |
|  | Rashes |  | Joint Swelling |  | Urinary Leakage |
|  | Change in Bowel Habits |  | Unexplained weight loss |  | Depression/Anxiety |
|  | Heart Palpitations |  | Cough |  | Night Sweats |
|  | Urinary Pain |  | Fevers |  | Muscle Weakness |
|  | Frequent Urination |  | Abnormal Vaginal Bleeding |  | Pain with Intercourse |

**Women Urologic History**

MENSTRUAL HISTORY

Last menstrual period (1st day): \_\_\_\_\_\_\_\_\_ Age of first period: \_\_\_\_\_\_\_\_ Cycle lengths in days: \_\_\_\_\_\_

Length of time between periods: \_\_\_\_\_\_\_\_\_ Flow: [ ]  **Heavy** [ ]  **Medium** [ ]  **Light**

Bad Cramps?: **Yes** or **No**  Bleeding in between?: **Yes** or **No**

Bleeding after intercourse?: **Yes** or **No**  Abnormal discharge?: **Yes** or **No**

Method of contraception: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age of menopause: \_\_\_\_\_\_\_\_\_\_

Date of the last mammogram: \_\_\_\_\_\_\_\_\_\_\_ Normal?: **Yes** or **No**

History of breast problems?: **Yes** or **No** Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of the last pap smear: \_\_\_\_\_\_\_\_\_\_\_\_\_ Normal?: **Yes** or **No**

OBSTETRICAL HISTORY

Total # of Pregnancies: \_\_\_\_ # of Miscarriages: \_\_\_\_ # of Live Births: \_\_\_\_ # of Abortions: \_\_\_\_

# of Children Living Now: \_\_\_\_ # of Premature Births <37 weeks: \_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| DOB | Type of Delivery(Vaginal, C-Sec, Vacuum, Forceps) | Weeks Pregnant | Sex | Birthweight | Complications(D&C, bleeding, diabetes, hypertension, infection) |
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**Men Urologic History**

Last PSA or Prostate Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

History of Erectile Dysfunction?: **Yes** or **No**

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Personal or family history of Prostate Cancer? **Yes** or **No**  If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Diagnostic Studies**

Type of study (i.e. colonoscopy, u/s, labs) Year Where was study performed?

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Name of referring physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Name of Last Primary Care Provider if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I attest the information provided is, to the best of my own knowledge, true for my personal and family medical history.

**SIGNATURE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE** \_\_\_\_\_\_\_\_\_\_\_

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Office use only: H \_\_\_\_\_\_\_ W \_\_\_\_\_\_\_\_ BP \_\_\_\_\_\_\_ T \_\_\_\_\_\_\_ BMI \_\_\_\_\_\_\_ Urine \_\_\_\_\_\_\_