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: _____

_____

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

☐ No Known Allergies to Medication

Name of Allergen	Reaction	Date

Current Medications (include vitamins, calcium, herbs over the counter meds).

Name of Medication	Dose	Frequency	Started	Reason

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**

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

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

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 _____

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)

Men Urologic History

Last PSA: _____

History of ED?: **Yes** or **No** If yes please explain:_____

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

_____

Diagnostic Studies

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

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____

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** _____

Office use only: H _____ W _____ BP _____ T _____ BMI _____ Urine _____