Today's Date: ______________________

Name: _______________________________ DOB ___/ ___/____ Sex: M F

Address: ___________________________________ City ___________________ State: ____ Zip: __________

Best Phone Number: __________________________________ Alternate Number: ______________________

Email Address: ____

Emergency Contact Name & Number: ____

Occupation: _____________________________________ Height: ___________ Weight: _________lbs.

Name of your physician: ____

1. What brought you here today? ____

2. When did you first notice this problem? What symptoms did you notice?

____

____

3. What previous medical tests, diagnosis and/or treatment have you had for this problem? How has treatment helped?

____

____

4. Please list any allergies to drugs, medications, or food:____

5. Please list any medications or supplements you are currently taking:

Medication	How long have you taken it?	Dose

6. Other serious illnesses, surgeries, injuries?

Date:	Injury/Illness/Surgery	Treatment	Result

7. Family history

Allergies
Heart Problems
Diabetes
Cancer
Glaucoma
Stroke
Emotional Difficulties
Hypertension/High BP
Seizure Disorders
Tuberculosis

8. Please check any conditions or symptoms that **you presently have** or **have had in the past:**

GENERAL			CARDIOVASCULAR			FEMALE		
Past	**Present**	**Condition**	**Past**	**Present**	**Condition**	**Past**	**Present**	**Condition**
		Poor appetite			High blood pressure			Frequent urinary tract infection
		Excess appetite			Low blood pressure			Frequent vaginal infections
		Insomnia			Blood clots			Pain/itching of genitalia
		Fatigue			Palpitations			Genital lesions/discharge
		Night sweats			Chest pain			Pelvic inflammatory disease
		Sweat easily			Irregular heart beat			Irregular/painful periods
		Chills			Cold hands/feet			Abnormal bleeding
		Poor coordination			Fainting			Hot flashes
		Bleed/bruise easily			Difficult breathing			Ovarian cysts
		Catch cold easily			Swelling hands/feet			Fibroids
		Strong thirst			Murmur			Endometriosis
					Other____________			STD

SKIN/HAIR			RESPIRATORY			NEUROLOGICAL/PSYCHO-EMOTIONAL		
Past	**Present**	**Condition**	**Past**	**Present**	**Condition**	**Past**	**Present**	**Condition**
		Rashes			Asthma			Seizures
		Hives			Bronchitis			Tremors
		Itching			COPD			Numbness/tingling of limbs
		Eczema			Pneumonia			Multiple concussion
		Psoriasis			Cough			Facial pain
		Acne			Coughing blood			Paralysis
		Dryness			Phlegm or congestion			Depression
		Tumors/lumps			Winded easily			Anxiety/Stress
		Dry/brittle nails			Tuberculosis			Irritabiity
		Yellow nails			Pulmonary edema			Teeth grinding/clenching
		Foot fungus			Whooping cough			Other ___________________

HEAD/NECK & EARS			GASTROINTESTINAL			INFECTION SCREENING		
Past	**Present**	**Condition**	**Past**	**Present**	**Condition**	**Past**	**Present**	**Condition**
		Dizziness			Nausea			HIV
		Fainting			Vomiting			Hepatitis type: ____________
		Neck stiffness/pain			Diarrhea			Chlamydia
		Headaches			Blood in stools/b lack			Gonorrhea
		Migraines			Constipation			Syphilis
		Ear infection			Gas			Genital warts
		Ringing in ears			Rectal pain/cramps			HPV
		Decreased hearing			Hemorrhoids			Herpes: oral
		Other: __________			Bad breath			Herpes: genital
					Hearburn/acid reflux			Lymes disease

EYES			GENITO-URINARY			MUSCULO-SKELETAL		
Past	**Present**	**Condition**	**Past**	**Present**	**Condition**	**Past**	**Present**	**Condition**
		Blurred vision			Kidney stones			Stiff neck/shoulders
		Visual changes			Pain on urination			Low back pain
		Poor night vision			Frequent urination			Muscle spasm or cramps
		Spots			Blood in urine			Sore, cold, or weak knees
		Cataracts			Urgency to urinate			Joint pain or stiffness
		Glasses/contacts			Unable to hold urine			Muscle weakness
		Eye inflammation			Strong smelling urine			Fibromyalgia
		Other:___________			Other:_____________			Other: _______________

FOR WOMEN:

1. Are you pregnant now? Yes No Unsure

2. Indicate number of occurrences: Live Births: ______ Pregnancies:______ Miscarriages:_______ Abortions:_________

3. Age: First period _____ Onset of menopause: (if applicable) ____________

4. Date: Last Pap Smear _____ /_____ Last Mammogram _____ / ______

5. Any History of an Abnormal Pap Smear? Yes No If so, what / when? ___________________________________

6. Is your menses cycle regular? Yes No

   a) Average number of days of flow ______

   b) The flow is: Normal Heavy Light

   c) The color is: Normal Dark Purple Light Brown Brown

7. Do you have any of the following menstrual/reproduction related signs/symptoms?

Cramps PMS Vaginal discharge Difficulty with orgasm Pain with intercourse

Nausea Menstrual blood clots Breast distention Spotting between periods Emotional

FOR MEN:

1. Do you have any bothersome urinary symptoms? Yes No

If yes, please describe: ____

2. Check all that apply:

Erectile dysfunction Pain in testicles Difficulty with orgasm Frequent nighttime urination

Premature ejaculation Swelling of testicles Low sperm count Dribbling urination/weak stream

3. Do you get up at night to urinate? Yes No How often? ____

4. Have you sought Medical intervention for these problems? If so, when? _______________________________________

5. What treatments have you tried for these problems and how successful have they been?________________________

____

Lifestyle:

Smoking: Yes No How often? How much? ____

Alcohol: Yes No How often? How much? ____

Recreational Drug Use: Yes No How often? How much? ____

Nutrition:

What do you typically eat for the following:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

How much water do you drink per day?____

How much caffeine do you drink per day?____

Exercise:

What is your daily activity level related to your occupation:

Sedentary i.e mostly sitting somewhat active
moderately active very active (moving around or up most of the time)
heavy duty (lifting, moving thingd etc.)

Do you exercise? Yes No What do you do? ________________________ How often?________________________

Is there anything else you think we should know about you in order to provide you with the best care?

____

____

____