DOH Institute-Medical History Form

Patient Name: _____ DOB: _____ Today's Date_____

MEDICAL HISTORY (**Please include approximate date of diagnosis**):

CARDIOVASCULAR:	ONSET DATE:	ENDOCRINE:	ONSET DATE:
High blood pressure Heart disease Heart attack High cholesterol Blood clots Pacemaker/defibrillator Other_____	_____ _____ _____ _____ _____ _____ _____	Type 2 Diabetes Type 1 Diabetes ***Taking insulin? YES NO*** ***Name***_____ Prediabetes Thyroid Disease Other_____	_____ _____ _____ _____ _____
RESPIRATORY:	**ONSET DATE:**	**GASTROINTESTINAL:**	**ONSET DATE:**
Asthma COPD Covid-19 Shortness of breath Sleep apnea Other_____	_____ _____ _____ _____ _____ _____	Gerd/Heartburn Stomach ulcer Hiatal hernia Fatty liver/NASH Elevated liver enzymes Hepatitis **A B C** Cirrhosis Other _____	_____ _____ _____ _____ _____ _____ _____ _____
GENITOURINARY:	**ONSET DATE:**	**NEUROLOGICAL:**	**ONSET DATE:**
Kidney disease Kidney stones Other _____	_____ _____ _____	Stroke Transient Ischemic attack (TIA) Migraines Headaches Other _____	_____ _____ _____ _____ _____
MISC:	**ONSET DATE:**	**LAST EYE EXAM**_____	
Cancer (type)_____ Depression Anxiety Arthritis (type)_____ Other_____ Other _____	_____ _____ _____ _____ _____ _____	**LAST COLON CANCER SCREEN** _____ **LAST BREAST CANCER SCREEN** _____ **LAST DIABETIC FOOT EXAM**_____	
WEIGHT LOSS PRACTICES:	*Bariatric surgery:* YES NO Type _____ Date_____ Pounds lost _____	***Previous diets***: Weight Watchers Low carb/keto/Atkins Intermittent fasting Calorie counting/portion control Other:_____ Current exercise: YES NO Type _____ How often_____ days per week Limitations: _____ Heaviest previous weight _____ How long have you been overweight:_____years	

SOCIAL HISTORY:

Circle: Married Divorced Widow
Alcohol: Never Social Frequent
Type: Liquor Beer
Drinks per week_____
Illicit drug use: _____
Type:_____
Smoker: YES NO FORMER
Quit Date:_____
Type: Cigarettes E-smoker Cigars
Other _____
Packs per day_____
Occupation _____

FAMILY HISTORY:

MOTHER _____

_____

FATHER_____

_____

BROTHER/SISTER _____

_____

CHILDREN _____

_____

HEALTH CARE PROVIDERS:

PRIMARY:

_____

HEART:

_____

DIABETES/THYROID:

_____

KIDNEY:

_____

LIVER/GI:

_____

Previous hospitalizations/surgeries (please include approximate dates): _____

_____

_____ _____ _____ _____

Patient/Representative Signature Date Clinical Provider Signature Date

Patient Name: _____ DOB: _____ Today's Date_____

ALLERGIES: ☐ *See attached list*	FOOD: _____ _____	MEDICATIONS: _____ _____
MEDICATION/SUPPLEMENT NAME: ☐ *See attached list*	**DOSE:**	**FREQUENCY**

REVIEW OF SYSTEMS	***PLEASE CIRCLE ALL CURRENT POSITIVE FINDINGS.***
Cardiovascular	Chest Pain Murmur Palpitations Poor circulation Swelling in the legs or feet
Gastrointestinal	Bloody Stools Constipation Diarrhea Frequent heartburn Nausea Vomiting
Constitutional	Chills Fevers Fatigue Insomnia Poor appetite Weight gain Weight loss
ENT	Hearing Loss Hoarseness Nosebleeds Sinus Problems Sore Throat
Eyes	Blurry Vision Eye Pain Decrease in Vision Dry Eyes Double Vision
Musculoskeletal	Back pain Frequent leg cramps Joint Pain Joint Swelling Muscle aches Muscle Weakness
Neurological	Dizziness/Vertigo Loss of balance Numbness Migraines Seizures Tremors
Psychiatric	Anxiety Alcohol or drug dependence Depression Use of antidepressants Panic attacks Suicidal Ideation
Respiratory	Chronic Cough Coughing up blood Shortness of Breath History of tuberculosis
Skin	Hives Hair loss Itching Nail Changes Mole changes Skin sores or ulcers Rash

FOOD ADDICTION SCREENING-***CIRCLE ALL THAT APPLY. GIVE YOURSELF 1 POINT FOR EACH CIRCLED ANSWER.***				
I have cut back on carbohydrates/sugar in the past.	I sometimes eat even though I am not hungry.	I find myself searching for sweet or starchy foods.	I feel guilty about eating carbohydrates/sugar.	A meal of only meat and vegetables leaves me feeling unsatisfied.
After a large meal, I feel sluggish, tired, and foggy.	I feel that I need bread with lunch and dinner.	I feel that I need to start my day with eating carbohydrates/sugar.	I feel that I can not live without my favorite high-carbohydrate food.	I experience withdrawal symptoms (headache, mood swings, trouble sleeping) when I limit carbohydrates/sugar.
TOTAL NUMBER OF POINTS: _____	***0-2 Not dependent of carbohydrates***	***3-4 I have a mild carbohydrate addiction***	***5-7 I have a moderate carbohydrate addiction***	***8-10 I have a severe carbohydrate addiction.***

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform my medical provider of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services that I may need.

_____ _____ _____ _____

Patient/Representative Signature Date Clinical Provider Signature Date