Philip J. A. Ryan, M.D. ◆ DELC INC

Phone (304) 260-1060 ◆ Fax (304) 260-1062 ◆ delc@delc.me

Patient's Personal Information

Name (legal/preferred): _____

Today's Date: _____ Phone #: _____ Email: _____

Birth Date: _____ Age: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex (circle one): M F I Gender: _____ Pronouns: _____

Sexual Orientation: _____ First Language: _____

Race: _____ Ethnicity: _____ Housing Status: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Contact's Phone #: _____

Relationship to Contact: _____ Contact's Email: _____

How did you learn about us? _____

Why are you seeking treatment? _____

_____

_____

_____

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Patient's Social History

Circle last year of school attended:

Grade school 1 2 3 4 5

Middle School 6 7 8

High School 9 10 11 12 GED

College 1 2 3 4

Grad School Master's Doctorate

Have you recently traveled outside of this region? If so, where and when?

_____

Have you served in the military? If so, for how long? _____

_____

Have you been rejected for military service? If so, why? _____

_____

Do you eat less than three meals a day? If so, why and how often? _____

_____

Do you have specific food customs or restrictions? If so, what are they? _____

_____

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Patient's Social History

Have you ever been treated for addiction? If so, when and where? _____

_____

Do you have hobbies? What are they? _____

Are you active in community, political, or church activities? If so, where? _____

_____

Have you taken a vacation in the last 12 months? Why or why not? _____

_____

Have you been married more than once? If so, how many times and when? _____

_____

Has there been a change in your marital status/relationship? If so, why? _____

_____

Have you ever questioned your sexuality? If so, in what ways? _____

_____

What are your sexual practices? _____

Have you questioned your gender? if so, are you interested in hormone therapy? ____

_____

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Patient's Occupational History

Are you currently employed? If so, how often do you work? _____

_____

Are you unemployed? If so, why? _____

_____

Do you have more than one job? If so, why? _____

_____

Does your work expose you to dust, noise, radioactivity, and or disease(s)? _____

_____

Do you have difficulty getting along with your coworkers? If so, why? _____

_____

Are you dissatisfied with your work? If so, why? _____

_____

Are you unable to work because of a disability? If so, what disability/ies? _____

_____

Have you missed more than 10 workdays in the past 6 months? If so, why? _____

_____

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Patient's Occupational History

Are you retired? If so, for how long? _____

If you're retired, have you had difficulty adjusting? _____

Are you a migrant worker? _____

Do you perform housework? How do you feel about that work? _____

_____

_____

If you're married, does your spouse help you with housework? If so, what ratio of housework would you say you and your spouse perform? _____

_____

Do you want more from life? If so, what do you want? _____

_____

_____

Address any other occupational concerns that haven't yet been discussed:

_____

_____

_____

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Patient's Habit History

Do you smoke tobacco? If so, what kind, how frequently, and for how long?

_____

_____

Do you drink alcoholic beverages? If so, what kind and how often?

_____

_____

Do you drink caffeinated beverages? If so, what kind and how often? _____

_____

Do you drink soft drinks? If so, what kind and how often? _____

_____

Do you use recreational drugs? If so, what kind and how often? _____

_____

Do you have difficulty sleeping? If so, when and how often? _____

_____

Do you wake up early and have difficulty falling back asleep? If so, how often? _____

_____

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Patient's Family History

Mother's name: _____ Age: _____

Is she alive? _____ If not, when and how did she die? _____

_____

Provide a brief history of your mother's health. Include diseases, conditions, surgeries, and hospitalizations: _____

_____

_____

_____

Father's name: _____ Age: _____

Is he alive? _____ If not, when and how did he die? _____

_____

Provide a brief history of your father's health. Include diseases, conditions, surgeries, and hospitalizations: _____

_____

_____

_____

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Patient's Family History

Check the conditions which apply to your blood relatives and identify your relationship to your family member(s):

___ Stroke

___ Cancer

___ High blood pressure

___ Pre-diabetes

___ Hypoglycemia

___ Glucose intolerance

___ Epilepsy

___ Osteoporosis

___ Obesity

___ Asthma

___ Heart attack

___ Stomach ulcers

___ Kidney disease/stones

___ High cholesterol

___ Depression

___ Anxiety

___ Goiter/Thyroid

___ Arthritis

___ Mental health crisis

___ Gout

___ Anemia

___ Severe allergies

___ Adrenal disorders

___ Migraines

___ Bipolar

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Patient's Family History

Do you have siblings? If so, how many and what are their sexes? _____

_____

_____

Do you have children? If so, how many and what are their sexes? _____

_____

_____

Use this space to discuss any other pertinent medical information about blood relatives which relates to your health: _____

_____

_____

_____

_____

_____

_____

_____

_____

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Patient's Medical History

Check all of the following illnesses and conditions that apply to you:

___ Rheumatic fever
___ Angina Pectoris
___ Heart attack
___ Other heart disease(s)
___ High blood pressure
___ Anemia
___ Kidney disease
___ Gout
___ Hay Fever
___ Asthma
___ Bronchial/Lung infections
___ Emphysema
___ Diabetes
___ Kidney stones
___ High cholesterol

___ Cancer/Tumor(s)
___ Kidney/Bladder infections
___ Thyroid disease
___ Gallbladder disease
___ Hepatitis
___ Colitis
___ Arthritis
___ Migraines
___ Osteoporosis
___ Radiation therapy
___ Chemotherapy
___ Depression
___ Anxiety
___ Bipolar
___ Stroke

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Patient's Medical History

Check all that apply to you:

___ Very tender and sensitive skin
___ Cuts stay open for long periods of time
___ Face often gets badly flushed
___ Sweat a great deal in cold weather
___ Need glasses/contacts to read
___ Eyesight has blacked out completely
___ Eyes continually blink or water
___ Often have painful eyes
___ Eyes are often red or inflamed
___ Blurring of your vision
___ Double vision
___ Glaucoma
___ High blood pressure
___ Low blood pressure
___ Difficulty breathing while lying down
___ Use eye drops
___ Cataracts
___ Very dry eyes
___ Heart/chest pains
___ Heart trouble
___ Heart racing
___ Heart thumping
___ Irregular heartbeat
___ Heart murmur
___ Difficulty breathing
___ Quickly out of breath
___ Swollen ankles
___ Wake up out of breath
___ Frequent leg cramps

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Patient's Medical History

Check all that apply to you:

___ Deaf/Hard of hearing

___ Runny ear

___ Noises in your ears

___ Constant runny nose

___ Chronic nose/throat issues

___ Frequent nose bleeds

___ Common cold incapacitates you

___ Inflammation of the veins

___ Have had an x-ray/cat scan

___ Frequent constipation

___ Diarrhea

___ Bloody diarrhea/stool

___ Bowel habits have changed

___ Intestinal worms

___ Often get up at night to urinate

___ Jaundice

___ Rectal hemorrhoids

___ Liver/gall bladder trouble

___ Difficulty swallowing

___ Hiatal hernia

___ Vomiting blood

___ Black/tarry stools

___ Stomach x-ray

___ Colon x-ray

___ Gall bladder x-ray

___ Abdomen x-ray

___ Painful joints

___ Swollen joints

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Patient's Medical History

Check all that apply to you:

___ Need constant stimulation
___ Low self esteem
___ Anorexia
___ Trouble relaxing
___ Everything takes effort
___ Wake up exhausted
___ Bulimia
___ Difficulty falling asleep
___ Insomnia
___ Difficulty going back to sleep
___ Life looks hopeless
___ You wish you were dead
___ You experience suicidal ideation
___ You feel useful and needed
___ You're happy with yourself

___ Constant worrying
___ Chronic depression
___ Stressed about finances
___ No leisure time
___ Tough childhood
___ Feel used by people
___ Feel unsafe in your home
___ Family history of depression
___ Family history of anxiety
___ Family history of bipolar
___ Generational abuse
___ Generational trauma
___ Childhood sexual abuse
___ Survivor of sexual assault
___ Incest survivor

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Patient's Medical History

Check all that apply to you:

___ People often annoy you

___ Short temper

___ Often go into a violent rage

___ Frequent shaking/trembling

___ Sudden noises make you jump

___ Experience weakness when someone shouts

___ Scared of sudden movements

___ Frequent and horrifying night terrors

___ Often break out in a cold sweat

___ Uncontrollable frightening thoughts

___ Obsessive compulsive tendencies and behavior

___ Feel as if you are "white knuckling it through life"

___ You do not identify with the gender you were assigned at birth

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Patient's Medical History

ASSIGNED FEMALE AT BIRTH (AFAB) ONLY

Are you menstruating? _____ If so, at what age did you begin? _____

Date of last period _____ Do you have a heavy flow? _____

Number of days from first day of period to first day of next period? _____

Do you spot/bleed in-between periods? If, so how often? _____

Is menstruating painful for you? If so, in what ways? _____

_____

Do you experience weakness/illness during menstruation? If yes, how so? _____

_____

Date of last pap smear _____ Date of last mammogram _____

Have you ever had issues with your breasts? If yes, how so?_____

_____

Do you examine your breasts once a month? _____

Have you sought medical treatment for your genitals? If so, why/why not? _____

_____

Do you take calcium supplements for your bones? _____

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Patient's Medical History

ASSIGNED MALE AT BIRTH (AMAB) ONLY

Do you have trouble starting your urine stream? If so, for how long? _____

_____

Has the size or force of your stream changed? If so, when? _____

_____

Have you ever had an enlarged testicle or scrotum? If so, when and why? _____

_____

Do you have issues performing sex or operating within your domestic life? _____

_____

Do you examine your testicles once per month? _____

Are you experiencing testosterone deficiency? _____

Do you have issues with your prostate? _____

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Patient's Medical History

Check the medications that you are taking:

___ Antacids

___ Asthma/wheezing medicine

___ Thyroid medication

___ Cough medicine

___ Digitalis/heart medicine

___ Dilantin

___ Water pills/diuretics

___ Nerve/muscle relaxants

___ Cortisone or prednisone
- ___ Mouth
- ___ Injection

___ Birth control pills

___ IUD

___ Blood pressure pills

___ Estrogen

___ Hormones

___ Insulin/diabetes pills

___ Antibiotics

___ Vitamins

___ Herbs

Indicate any other medications you are taking _____

_____

_____

_____

_____

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Patient's Medical History

Indicate other illnesses or conditions you have experienced and when:

_____

_____

_____

_____

List surgeries you have undergone and indicate corresponding years:

_____

_____

_____

_____

List hospitalizations (non-surgical) and state medical reasons and dates:

_____

_____

_____

_____

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Patient's Medical History

Primary Care Physician — name, address, phone #, and duration of care:

_____

_____

_____

_____

_____

Other Physicians: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____