

new patient health history

name: _____ date: _____

address: _____

city: _____ state: _____ zip: _____

telephone (home): _____ (work): _____

(mobile): _____

email address: _____

how would you prefer to be contacted? home work mobile email

may we leave a message? home work mobile email

age: _____ date of birth: _____ gender: female / male

married: ___ separated: ___ divorced: ___ widowed: ___ single: ___ partnership: ___

live with: spouse: ___ partner: ___ parents: ___ children: ___ friends: ___ alone: ___

occupation: _____ hours per week: _____

how did you hear about this clinic? _____

emergency contact: _____ phone: _____

relationship: _____

what are your most important health concerns?

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____

do you have any contagious diseases at this time: yes / no

if yes, what? _____

height: _____ weight: _____ weight one year ago: _____
maximum weight: _____ when: _____
what time of day is your energy the best: _____ worst: _____
main interests and hobbies: _____
exercise: yes / no if yes, what kind and how often: _____
watch t.v.: yes / no if yes, how many hours: _____
read: yes / no if yes, how many hours: _____
do you have a religious or spiritual practice? yes / no if yes, what kind? _____

family history

do you have a family history of any of the following? (please circle)

cancer	epilepsy	kidney disease
diabetes	arthritis	asthma
heart disease	glaucoma	hives
high blood pressure	mental illness	hay fever
stroke	alcoholism	osteoporosis

any other relevant family history? _____

childhood illnesses

have you ever had any of these childhood illnesses? (please circle)

rheumatic fever	measles	chicken pox	mumps
diphtheria	scarlet fever	german measles	

hospitalizations/surgeries

please list any surgical procedures, hospitalizations you have had:

allergies

are you allergic or sensitive to:

any drugs? _____

any foods? _____

any environmental factors or chemicals? _____

current medications

do you use any of the following? (please circle)

- | | | |
|---------------------|----------------|---------------------|
| laxatives | pain relievers | antacids |
| antibiotics | tranquilizers | sleeping pills |
| thyroid medication | cortisone | birth control pills |
| hormone replacement | | |

please list any prescription medications, over the counter medications, vitamins, or other supplements you are taking:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 8) _____
- 9) _____
- 10) _____

typical diet

breakfast: _____

lunch: _____

dinner: _____

snacks: _____

drinks: _____

general

- | | | | |
|--------------------------|----------|----------------------------|----------|
| do you sleep well? | yes / no | eat three meals a day? | yes / no |
| average 6-8 hours? | yes / no | do you diet often? | yes / no |
| awake rested? | yes / no | eat out often? | yes / no |
| use alcoholic beverages? | yes / no | drink coffee? | yes / no |
| use tobacco? | yes / no | drink black/green tea? | yes / no |
| use recreational drugs? | yes / no | do you eat refined sugar? | yes / no |
| do you enjoy your work? | yes / no | use artificial sweeteners? | yes / no |
| take vacations? | yes / no | add salt to your food? | yes / no |

for the following, please circle only those that apply:

c = a condition you currently have

p = a significant problem in the past

ears, eyes, nose, throat

impaired hearing	c	p	headaches	c	p
ringing in ears	c	p	frequent colds	c	p
dizziness	c	p	frequent sore throats	c	p
ear aches	c	p	hoarseness	c	p
impaired vision	c	p	jaw or tmj problems	c	p
cataracts	c	p	teeth grinding	c	p
glaucoma	c	p	lumps in neck	c	p
spots in vision	c	p	difficulty swallowing	c	p
color blindness	c	p	sinus problems?	c	p
tearing or dryness	c	p	hayfever	c	p
eye pain or strain	c	p	loss of smell	c	p
double vision	c	p	head injury	c	p

respiratory

cough	c	p	pneumonia	c	p
sputum	c	p	pleurisy	c	p
asthma	c	p	difficulty breathing	c	p
wheezing	c	p	shortness of breath	c	p
bronchitis	c	p	emphysema	c	p
coughing up blood	c	p	tuberculosis	c	p

immune

slow wound healing	c	p	chronic infections	c	p
chronic fatigue syndrome	c	p	night sweats	c	p

endocrine

hypothyroid	c	p	heat or cold intolerance	c	p
hyperthyroid	c	p	diabetes	c	p
hypoglycemia	c	p	excessive hunger	c	p
excessive thirst	c	p	fatigue	c	p
hair loss	c	p			

women's health

age of first menses	_____		date of last pap	_____	
date of last menses	_____		abnormal pap	c	p
length of cycle	_____		cervical dysplasia	c	p
duration on menses	_____		birth control	c	p
are your cycles regular	yes / no		pain during intercourse	c	p
painful menses	c	p	sexually transmitted disease	c	p
heavy flow	c	p	difficulty conceiving	c	p
pms	c	p	number of pregnancies	_____	
bleeding between cycles	c	p	number of live births	_____	
clotting	c	p	number of miscarriages	_____	
endometriosis	c	p	number of abortions	_____	
ovarian cysts	c	p	breast pain/tenderness	c	p
vaginal discharge	c	p	breast lumps	c	p
nipple discharge	c	p	menopausal symptoms	c	p

men's health

hernias	c	p	impotence	c	p
testicular pain	c	p	premature ejaculation	c	p
testicular masses	c	p	sexually transmitted disease	c	p
prostate disease	c	p			

cardiovascular

heart disease	c	p	blood clots	c	p
angina	c	p	palpitations	c	p
high blood pressure	c	p	rheumatic fever	c	p
low blood pressure	c	p	varicose veins	c	p
heart murmurs	c	p	swelling of ankles	c	p

gastrointestinal

nausea/vomiting	c	p	change in appetite	c	p
ulcer	c	p	abdominal pain	c	p
jaundice	c	p	irritable bowel syndrome	c	p
gall bladder disease	c	p	crohn's disease	c	p
liver disease	c	p	belching	c	p
hemorrhoids	c	p	gas	c	p
pancreatitis	c	p	constipation	c	p
heartburn	c	p	diarrhea	c	p

urinary

increased frequency	c	p	frequency at night	c	p
inability to hold urine	c	p	frequent UTIs	c	p
pain on urination	c	p	kidney stones	c	p

neurological

seizures	c	p	paralysis	c	p
muscle weakness	c	p	numbness or tingling	c	p
loss of memory	c	p	loss of balance	c	p
vertigo or dizziness	c	p	fainting	c	p

musculoskeletal

joint pain or stiffness	c	p	neck/shoulder pain	c	p
arthritis	c	p	upper back pain	c	p
broken bones	c	p	lower back pain	c	p
muscle spasms	c	p	arm/wrist pain	c	p
muscle cramps	c	p	leg pain	c	p

skin

rashes	c	p	eczema	c	p
acne	c	p	hives	c	p
change in skin color	c	p	itching	c	p

mental/emotional

poor concentration	c	p	considered suicide	c	p
memory problems	c	p	attempted suicide	c	p
depression	c	p	eating disorders	c	p
anxiety	c	p	insomnia	c	p
mood swings	c	p	frequent crying	c	p
panic attacks	c	p			