



A Total Life Concept For Healthcare, Fitness, Nutrition, and Behavioral Health

Patient History Form

Today's Date: _____

Patient Name: _____ DOB: _____

Please answer these questions to the best of your knowledge.

** If you have any questions, **please star (*)** it so we can address at your visit.

PAST MEDICAL HISTORY

1. Check off the following diagnoses that you have **now** or have had **in the past**.
2. Please **circle** the diagnosis if this is a **current** problem for you.
3. Indicate **when** (i.e. childhood) you were diagnosed and any **specifics** (eg type of cancer).

Diagnosis:	Age/Details	Diagnosis:	Age/Details
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Measles		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Mumps		<input type="checkbox"/> Blood clots in lung or leg	
<input type="checkbox"/> Rubella		<input type="checkbox"/> Abnormal bleeding	
<input type="checkbox"/> Scarlet Fever		<input type="checkbox"/> Anemia	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Thyroid disorder	
<input type="checkbox"/> COPD		<input type="checkbox"/> Hepatitis/liver disorder	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Gall bladder problems	
<input type="checkbox"/> Allergies		<input type="checkbox"/> Reflux or ulcers	
<input type="checkbox"/> Eczema/skin rashes		<input type="checkbox"/> Colitis	
<input type="checkbox"/> Bronchitis		<input type="checkbox"/> Kidney disease	
<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/> Tuberculosis		<input type="checkbox"/> Degenerative arthritis	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Gout	
<input type="checkbox"/> High blood pressure		<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> High cholesterol		<input type="checkbox"/> Cancer:	
<input type="checkbox"/> Heart disease		<input type="checkbox"/> Parkinson's disease	
<input type="checkbox"/> Mitral valve prolapse		<input type="checkbox"/> Shingles	
<input type="checkbox"/> Heart murmur		<input type="checkbox"/> Prostate problems	
<input type="checkbox"/> Psychiatric disorders		<input type="checkbox"/> Chronic urinary infection	
<input type="checkbox"/> Depression/anxiety		<input type="checkbox"/> Irritable bowel syndrome	
<input type="checkbox"/> Migraine headaches		<input type="checkbox"/> Incontinence	

Other problems not listed:

2. SURGICAL HISTORY

Procedure:

Date:

1. _____
2. _____
3. _____

4. _____
5. _____

3. HOSPITALIZATIONS: (not including above surgeries or childbirth)

- | | |
|----------|-------|
| Reason: | Date: |
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

4. GYNECOLOGIC HISTORY: (females only)

1. Total # pregnancies _____
 # live births ____ vaginal deliveries ____ C-sections ____ miscarriages ____ abortions ____
2. At what age did your menstrual periods begin? _____
3. At what age did your menstrual periods stop (menopause)? _____

5. SERIOUS INJURIES OR ACCIDENTS:

- | | |
|------------------|-------|
| Injury/accident: | Year: |
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |

6. Have you ever had a blood transfusion? Yes No

If yes, what was the reason? _____ Year: _____

7. Do you routinely take antibiotics prior to procedures, such as dental visits to prevent heart or joint infections? Yes No

If yes, why? _____

What is prescribed? _____

FAMILY HISTORY

List any BLOOD relatives with the following issues. If grandparents or aunt/uncle, please specify whether this relative is on your mother's side (**maternal**) or father's side (**paternal**) and age at onset.

1. Diabetes:

_____	Age at onset: _____
_____	Age at onset: _____
2. High blood pressure:

_____	Age at onset: _____
_____	Age at onset: _____
3. Heart attack, angina, coronary bypass, or other:

_____	Age at onset: _____
_____	Age at onset: _____
4. Stroke:

_____	Age at onset: _____
_____	Age at onset: _____
5. Cancer:

_____	Type: _____	Age at onset: _____
_____	Type: _____	Age at onset: _____

_____ Type: _____ Age at onset: _____

6. Are there any other illnesses that are common in your family? **For example:** high cholesterol, mental disorder, thyroid problems, gall bladder disease, gastrointestinal issues, bleeding or clotting disorders, depression, substance abuse, etc.

Illness: _____ Relation: _____ Age at onset: _____
Illness: _____ Relation: _____ Age at onset: _____
Illness: _____ Relation: _____ Age at onset: _____

SOCIAL HISTORY

1. Current Marital Status: Single Partner/Married Separated Divorced Widowed Other
2. What is your spouse/partner's name? _____
3. How many times have you been married? _____
4. Years in current relationship: _____
5. What is your current method of contraception? _____
6. With whom do you live? _____
7. Please list your biological children, if any:
 1. _____ Date of Birth _____ Living? Y N
 2. _____ Date of Birth _____ Living? Y N
 3. _____ Date of Birth _____ Living? Y N
 4. _____ Date of Birth _____ Living? Y N
8. List any other children living in your home and ages: _____
9. Employment: Full time Part time Retired Other: _____
10. Occupation: _____ Employer: _____
11. Religious Affiliation: _____
12. Years of education/highest degree (include other education such as associates degree, technical or vocational school certifications) _____
13. Degree and/or major: _____
14. Hobbies: _____
15. Regular exercise: Yes No
_____ How often/duration? _____
_____ How often/duration? _____
16. Habits: **Please indicate amounts if marking Yes.**
 - a. Do you drink caffeine? No Yes
_____ cups/glasses of coffee/tea/soda per day
 - b. Do you now use, or have you ever used, tobacco? No Yes
 1. Cigarettes: age started _____ age stopped _____ amount/day: _____
 2. Pipe or cigars: No Yes amount: _____
 3. Smokeless tobacco No Yes amount: _____
 - c. Do you drink alcohol? No Yes (if Yes, please specify # per day, week, or year)
 1. _____ beers per day/week/year
 2. _____ glasses of wine per day/week/year
 3. _____ ounces hard liquor (or mixed drinks) per day/week/year

17. Have you ever had problems with alcohol or drugs? No Yes
 Now _____ or in the past _____ ?
18. Do you currently use recreational drugs (includes marijuana)? No Yes
 If yes, what type(s)? _____

HEALTH MAINTENANCE (indicate date of most recent):

1. Physical exam: _____
2. Cholesterol: _____ was it normal or elevated?
3. Diabetes Screen (sugar): _____ was it normal or elevated?
4. Colonoscopy: _____ precancerous polyps found? Yes / No
5. Vision exam: _____ Dental exam: _____
6. Date of your **most recent immunizations**:
 Tetanus/Pertussis _____ Pneumovax _____ Influenza (Flu): _____
 Hepatitis B (series of 3) _____ Hepatitis A _____ Zostavax: _____
7. Women: Mammogram: _____ was it normal? Yes / No: _____
 Dexascan (bone density): _____ was it normal? Yes / No: _____
 Pap smear: _____ was it normal? Yes / No: _____
8. Men: PSA (prostate cancer screening): _____ was it normal? Yes / No
9. Do you have Advanced Directives? No Yes
 If yes, check which documents you have completed:
 ____ living will ____ durable power of attorney ____ CPR directive

Please circle other treatment modalities you have used and indicate what the treatment was for:

- Acupuncture _____
- Physical therapy _____
- Homeopathy _____
- Herbal therapy (oriental or naturopathic) _____
- Counseling _____
- Chiropractic manipulation _____
- Osteopathic manipulation _____
- Nutrition counseling _____
- Other (list): _____

