

Drugs (prescription and over-the-counter, that you are now taking):

| Name of drug | Reason for drug | Dose (mg/etc) | For how long | Prescribing doctor |
|--------------|-----------------|---------------|--------------|--------------------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Allergies [drugs, food, environmental (grass/pollen, etc.) Please **circle any, which are life-threatening**]:

Medical / Health History:

Primary Care Doctor/Provider (if any): _____ Date last seen: _____

Reason for seeing: _____

Clinic Name: _____ Doctor's phone:() _____ Fax:() _____

Doctors full address: _____

| Other <u>Current</u> Health Provider(s): | Type: | Phone: | Fax: |
|--|-------|-----------|-----------|
| _____ | _____ | () _____ | () _____ |
| _____ | _____ | () _____ | () _____ |
| _____ | _____ | () _____ | () _____ |

Date of last full physical exam: _____, Results: normal other(_____)

Date of last urine test: _____, Results: normal other(_____)

Date of last blood work: _____, Results: normal other(_____)

Outpatient Procedures / Hospitalizations (surgeries/ special diagnostic studies):

| Type (of surgery/study) | Date | Reason for procedure/ admission | Outcome / Results |
|-------------------------|-------|---------------------------------|-------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Major Illnesses/emotional or physical trauma/ accidents (not already listed):

| | | | |
|-------|-------|---------------------|----------|
| Type: | Date: | Treatment received: | Outcome: |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Family History (Using the following key, designate which family members have had the following. List type where parentheses are present):

M=Mother F=Father B=Brother S=Sister G=Grandparent C=Child

| condition | who | condition | who | condition | who |
|-----------------------|-----|---------------------|-----|---------------------|-----|
| Allergies | | Diabetes | | Kidney disease | |
| Alcoholism | | Cancer () | | Mental disorder () | |
| Anemia | | Cancer () | | Obesity | |
| Arthritis(Rheumatoid) | | Epilepsy | | Stroke | |
| Arthritis(Osteo) | | Heart Disease | | Thyroid (low/ high) | |
| Auto Immune disease | | High Blood Pressure | | Other: () | |
| Bleeding tendency | | High Cholesterol | | Other: () | |

Social History (please circle, or complete if applicable):

Parents: Married Separated Divorced

Mother's Occupation: _____ Full Time: _____ Part Time: _____

Father's Occupation: _____ Full Time: _____ Part Time: _____

Guardian: _____ Relationship: _____

| | | | |
|-----------|-------|-------|-----------------|
| Siblings: | Name | Age | Health Problems |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

Other's residing in the home and their relationship: _____

Sleep Habits:

How many hours/night: _____ Does sleep refresh you? _____ If not why? _____

What time do you usually go to sleep? _____ What time do you usually wake up? _____

Review of Systems (Health History) please check:

| | | | |
|------|-------------------|------|-------------------------|
| Past | Now | Past | Now |
| ___ | ___ Acne | ___ | ___ Eczema |
| ___ | ___ Allergies | ___ | ___ Epilepsy/Seizure |
| ___ | ___ Anemia | ___ | ___ Fatigue |
| ___ | ___ Asthma | ___ | ___ Frequent Infections |
| ___ | ___ Bed Wetting | ___ | ___ Headaches |
| ___ | ___ Birth Defects | ___ | ___ Heart Murmur |
| ___ | ___ Colic | ___ | ___ High Fever |
| ___ | ___ Croup | ___ | ___ Hyperactivity |
| ___ | ___ Constipation | ___ | ___ Insomnia |
| ___ | ___ Cough/Wheeze | ___ | ___ Jaundice |
| ___ | ___ Cradle Cap | ___ | ___ Learning Disorder |
| ___ | ___ Depression | ___ | ___ Moodiness |
| ___ | ___ Diarrhea | ___ | ___ Stuffy Nose |
| ___ | ___ Dizzy Spells | ___ | ___ Thrush |
| ___ | ___ Earaches | ___ | ___ Vomiting Spells |

Eliminations (please complete):

| Bowel movement habits | | Urine habits | |
|---|--|---|--|
| Frequency: (how often) Twice/ day, every week... | | Frequency: (how often per 24hour period) | |
| Color: (black, brown, yellow, green, white) | | Color: (dark yellow, light yellow, green, colorless) | |
| Consistency: (hard, formed, soft, watery) | | Character: (clear, cloudy, concentrated, dilute) | |
| Any mucus or blood on stool? (which) | | Any blood or sediment? (which) | |
| Does stool pass easily? | | Any pain, incontinence, other urinary symptoms? | |

Digestion: Any stomach upset, bloating, burping, flatulence (gas), nausea, or rectal itching after food?
(circle or specify):

Anything else you want us to know? _____
