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Medical Options For Wellness
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Adult Health History

Name: _____ DOB: _____ Age: _____
Occupation: _____ Who referred you? _____

Current Medical Problems

Please list the medical problems for which you came to see the doctor. About when did they begin?

Problems	Date began
_____	_____
_____	_____
_____	_____

What concerns you most about these problems? _____
Are you being treated for any other illnesses or medical problems by another physician?

Illness or Medical Problem:	Physician or Medical Facility:
_____	_____
_____	_____

Medications List all medications you are now taking.

_____	_____	_____
_____	_____	_____

Allergies and Sensitivities List all medications, foods, supplements that you are allergic to:

Allergic to:	Effect:	Allergic to:	Effect:
_____	_____	_____	_____
_____	_____	_____	_____

General Health

How is your overall health now?	Poor ___ Fair ___ Good ___ Excellent ___
In the past year	
Has your appetite changed?	Decreased ___ Increased ___ Stayed Same ___
Has your weight changed?	Lost ___ lbs. Gained ___ lbs. No Change ___
Are you thirsty much of the time?	No ___ Yes ___
Has your overall 'pep' changed?	Decreased ___ Increased ___ Stayed Same ___
Do you usually have trouble sleeping?	No ___ Yes ___
How much do you exercise?	None ___ 1-2 x/wk ___ 3-4 x/wk ___
Do you smoke?	No ___ Yes ___ No. of Years ___
Do you drink alcoholic beverages?	No ___ Yes ___ No. of Drinks/wk ___
Have you ever had a problem with alcohol?	No ___ Yes ___
How much coffee/tea do you usually drink?	_____ cups of coffee/tea per day

Adult Health History

DO YOU:	Rare	Occasional	Frequent
Feel nervous	____	____	____
Feel depressed	____	____	____
Find it hard to make decisions	____	____	____
Lose your temper	____	____	____
Ever feel like committing suicide	____	____	____
Tire easily	____	____	____
Have trouble relaxing	____	____	____
Have any sexual problems	____	____	____

DO YOU:	Rare	Occasional	Frequent
Worry a lot	____	____	____
Use marijuana	____	____	____
Feel bored with your life	____	____	____
Use hard drugs	____	____	____
Do you want to talk to the doctor about a personal matter	No ___	Yes ___	

Have you recently had any changes in your:			If yes, please explain
Marital Status	No ____	Yes ____	_____
Job or Work	No ____	Yes ____	_____
Residence	No ____	Yes ____	_____
Financial Status	No ____	Yes ____	_____

Family History

Please give the following information about your immediate family:

Relationship	State of health or cause of death
Father	_____
Mother	_____
Brothers	_____
And	_____
Sisters	_____
	_____
Children	_____
	_____

Have any **blood relatives** had any of the following illnesses? If so, indicate relationship (ie brother, mother, etc.)

Illness	Family Members
Alcoholism	_____
Asthma	_____
Diabetes	_____
Cancer	_____
Blood Disease	_____
Epilepsy	_____
Rheumatoid Arthritis	_____
Gout	_____
High Blood Pressure	_____
Heart Disease	_____
Mental Problems	_____
Suicide	_____
Stroke	_____

Travel History

List all foreign countries visited:

_____

_____

_____

Adult Health History

WOMEN ONLY

Last menstrual period _____
Heavy periods _____
Irregular periods _____
PMS _____
Breast lumps _____
Tender breasts _____
Nipple discharge _____
Hot flashes _____
Night Sweats _____
Vaginal discharge _____
Last pap __/__/__ abnormal? Y N
Last mammogram __/__/__ abnormal? Y N

MEN ONLY

Number of times you urinate at night _____
Difficulty starting urine _____
Frequent urination _____
Painful urination _____
Discharge from penis _____
Testicular pain, lumps, sores _____
Lose urine with cough or sneeze _____
Sexual questions you want to discuss _____

ALL

Severe shoulder pain	☐	Discharge from ears	☐
Severe back pain	☐	Dizzy or motion sickness	☐
Muscle/Joint stiffness or pain	☐	Ringing in ears	☐
Bruise easily	☐	Dry skin	☐
Moles that have changed in size or color	☐	Oily skin	☐
Skin rashes	☐	Numbness/tingling	☐
In last 3 months have had cold sores	☐	Severe headaches	☐
In last 3 months have had fevers	☐	Trouble with memory	☐
Lumps in neck, armpits, groin	☐	Difficulty with focusing/concentrating	☐
Difficulty with balance	☐	Athlete foot, jock itch or toenail fungus	☐
Has your vision changed in the past year	☐	Vaginal yeast infections	☐
Do you get double or blurry vision	☐	Thrush	☐
Itchy, watery eyes	☐	Insomnia	☐
Do you see rings around lights	☐	Bloody or dark bowel movements	☐
Hearing problem	☐	Date of last sigmoidoscopy	☐

How often do you have the following?:

	Rare	Occasional	Frequent
Head/chest colds	____	____	____
Runny nose	____	____	____
Sore throat	____	____	____
Coughing spells	____	____	____
Sneezing spells	____	____	____
Nose bleeds	____	____	____
Trouble breathing	____	____	____
Snoring	____	____	____

How often do you?:

	Rare	Occasional	Frequent
Get nauseated	____	____	____
Have stomach pains	____	____	____
Have heartburn	____	____	____
Trouble swallowing	____	____	____
Vomit blood	____	____	____
Have diarrhea	____	____	____
Have constipation	____	____	____
Painful bowel movements	____	____	____

Adult Health History

Have you ever spent time on the following (Circle Yes or No.):			Do you suffer from (Circle Yes or No.):		
Farm	Yes	No	Breathing Problems	Yes	No
Mine	Yes	No	Lightheadedness	Yes	No
Laundry	Yes	No	Fainting	Yes	No
Mill	Yes	No	Racing heart palpitations	Yes	No
Dusty Places	Yes	No	Chest pains	Yes	No
Near Toxic Chemicals	Yes	No	Leg cramps	Yes	No
Near radioactive Materials	Yes	No	Swollen Ankles	Yes	No
Near Asbestos	Yes	No			

DIET HISTORY

	More than once daily	Daily	3 times weekly	Once weekly	Twice monthly	Less or never
Grains, breads, cereals						
Milk and other dairy products						
Eggs						
Meat, poultry, fish						
Beans, peas, and other legumes						
Fruits						
Vegetables						

Additional Patient Comments: