

OTHER HOSPITALIZATIONS: Please list any other overnight hospital stays you have had: (i.e.: childbirth, pneumonia, psychiatric hospitalizations, etc.) Include reason for admission, dates, and hospital, if known.

DATE	REASON FOR ADMISSION	HOSPITAL

MEDICATIONS: Please list all medications that you take. Please include prescription drugs, OTC medications, vitamins, and supplements. Also include medication dose, number of pills taken, and how often:

MEDICATION	STRENGTH	NUMBER OF PILLS	HOW OFTEN

ALLERGIES: Please list allergies to medications, foods, and other substances. Please indicate what your reaction was. (i.e.; Penicillin →Hives, Cats→Wheezing)

MEDICATION/SUBSTANCE	REACTION

DIET: Please describe your usual dietary intake:

Starchy Foods (pasta, breads, potatoes)	<input type="checkbox"/> high	<input type="checkbox"/> medium	<input type="checkbox"/> low	<input type="checkbox"/> none
Sweets (candy, pastries, doughnuts)	<input type="checkbox"/> high	<input type="checkbox"/> medium	<input type="checkbox"/> low	<input type="checkbox"/> none
Fatty Foods (bacon, sausage, fried foods)	<input type="checkbox"/> high	<input type="checkbox"/> medium	<input type="checkbox"/> low	<input type="checkbox"/> none
Fruits	<input type="checkbox"/> high	<input type="checkbox"/> medium	<input type="checkbox"/> low	<input type="checkbox"/> none
Vegetables	<input type="checkbox"/> high	<input type="checkbox"/> medium	<input type="checkbox"/> low	<input type="checkbox"/> none
Dairy (milk, cheese, yogurt)	<input type="checkbox"/> high	<input type="checkbox"/> medium	<input type="checkbox"/> low	<input type="checkbox"/> none
Lean Meats (fish, chicken)	<input type="checkbox"/> high	<input type="checkbox"/> medium	<input type="checkbox"/> low	<input type="checkbox"/> none

Are there any foods you do not tolerate, or try to avoid? (i.e.: gluten, lactose, etc.)

Are you currently trying to lose weight, or are you considering it? no yes (currently)
 yes (considering)

EXERCISE:

Do you exercise regularly? Yes No

If so, what type and how often? _____

WORK:

Are you currently working/going to school? Please circle:

Yes, Full Time ♦ Yes, Part Time ♦ No, Retired ♦ No, Unemployed ♦ No, Disabled ♦ No, other:

Please describe current occupation/vocation: (Where and what you do)

Are you now, or have you in the past been exposed to hazards? (i.e.: asbestos, toxic chemicals, fumes, radiation, etc.)

No Yes (past) Yes (currently) If Yes, Please describe what and when:

MILITARY SERVICE:

Have you ever served in the military? No Yes, in past Yes, currently

If so, THANK YOU FOR YOUR SERVICE. Please describe service (branch, time in service, foreign posts, combat or other injuries and disabilities):

SOCIAL HISTORY:

TOBACCO:

Cigarettes: never smoked
 quit (please list packs per day, how many years, and date you quit) _____
 currently smoking (please list packs per day and when you started) _____

Cigars: never smoked
 quit (please list cigars per day or week, how many years, and date you quit) _____
 currently smoking (please list cigars per day or week and when you started) _____

Pipe: never smoked
 quit (please list how many years, and date you quit) _____
 currently smoking (please list times per day and when you started) _____

Chew: never used
 quit (please list cans per day, how many years, and date you quit) _____
 currently chewing (please list cans per day and when you started) _____

ALCOHOL: Please describe your alcohol use: (one drink= 12 oz. beer, 4 oz. wine, or 1 shot liquor)

never drank
 quit drinking alcohol (please list drinks per day and date you quit) _____
 currently drink alcohol
 very rarely occasionally socially regularly (circle)
 Number of drinks _____ per day week month year (circle)

Are you or anyone close to you concerned about how much you drink? No Yes

DRUGS: (Please describe your use of mind altering drugs, including type [marijuana, cocaine, pills not prescribed to you, ecstasy, etc.] and how much, and provide details.) **Please be honest. We ask for medical reasons. This is confidential.**

never used
 quit (please list types of drugs, how many years, and when you quit)

 currently using (please list types of drugs, when you started, and how often you use)

Are you or anyone close to you concerned about your drug use? No Yes

CAFFEINE: (Please describe how much caffeine you consume, including coffee, tea, sodas, etc.)

Coffee: _____ cups per day week (circle)
Tea: _____ cups per day week (circle)
Soda: _____ cans/btls per day week (circle)
Energy Drinks: _____ cans/shots per day week (circle)

RELATIONSHIP HISTORY:

Please describe current status: (circle) single married committed relationship divorced
separated widowed

Sexual Activity: (circle) currently active never active not currently active

If sexually active, do you use birth control? If so, method: _____

Do you feel safe in your current relationship? yes no N/A

FAMILY HISTORY: Please complete to the best of your ability.

RELATIONSHIP	M or F	living?	year of birth	MEDICAL PROBLEMS	AGE OF DEATH	CAUSE OF DEATH (IF APPLICABLE)
MOTHER	F					
FATHER	M					
Mat. GM	F					
Mat. GF	M					
Pat. GM	F					
Pat. GF	M					
SIBLINGS:						
CHILDREN						
OTHER SIGNIFICANT FAMILY HISTORY						

REVIEW OF SYSTEMS: Please circle any problems or symptoms you are having.

GENERAL: fever ♦ chills ♦ fatigue ♦ weight loss ♦ weight gain ♦ other:

EYES: blurred vision ♦ double vision ♦ watery eyes ♦ blindness ♦ eye pain ♦ other:

EARS: decreased hearing ♦ clogged ears ♦ ear pain ♦ ringing ♦ dizziness ♦ ear discharge ♦ other:

NOSE/SINUS: runny nose ♦ sinus congestion ♦ sinus pain ♦ bloody nose ♦ sneezing ♦ other:

MOUTH: dental problems ♦ cold sores ♦ tongue problems ♦ mouth/jaw pain ♦ other:

THROAT: sore throat ♦ post nasa drip ♦ painful swallowing ♦ burning in throat ♦ enlarged tonsils ♦ other:

RESPIRATORY: shortness of breath ♦ wheezing ♦ coughing ♦ asthma ♦ COPD ♦ other:

CARDIOVASCULAR: chest pain ♦ heart failure ♦ palpitations ♦ heart murmur ♦ aneurysms
high blood pressure ♦ lightheadedness ♦ swollen ankles ♦ cold hands and feet
leg cramping with walking ♦ anemia ♦ varicose veins ♦ other:

DIGESTIVE: decreased appetite ♦ difficulty swallowing ♦ heartburn ♦ stomach upset ♦ abdominal pain
nausea ♦ vomiting ♦ diarrhea ♦ constipation ♦ bloody bowel movements ♦ black bowel movements
hemorrhoids ♦ liver problems ♦ jaundice ♦ other:

KIDNEY: frequent urination ♦ painful urination ♦ blood in urine ♦ kidney stones ♦ kidney failure
difficulty passing urine ♦ waking at night to urinate often ♦ other:

GENITAL (WOMEN): painful periods ♦ heavy periods ♦ irregular periods ♦ painful intercourse
sexual difficulties ♦ vaginal dryness ♦ ovarian cysts ♦ fibroids ♦ difficulty getting pregnant ♦ PMS
endometriosis ♦ breast pain ♦ breast lumps ♦ nipple discharge ♦ other:

GENITAL (MEN): lump in testicles/scrotum ♦ pain in testicles/scrotum ♦ sexual difficulties
prostate problems ♦ difficulty with fertility ♦ other:

ENDOCRINE/GLANDS: intolerance to heat ♦ intolerance to cold ♦ thyroid problems
adrenal gland problems ♦ menopause issues ♦ low testosterone ♦ hair loss ♦ other:

SKIN: moles ♦ acne ♦ skin lumps/bumps ♦ eczema ♦ psoriasis ♦ skin cancers ♦ dry skin ♦ oily skin
rash ♦ nail problems ♦ hair problems ♦ itching ♦ other:

MUSCULOSKELETAL: back pain ♦ neck pain ♦ shoulder pain ♦ elbow pain ♦ wrist pain ♦ hand pain
hip pain ♦ knee pain ♦ ankle pain ♦ foot pain ♦ arthritis ♦ muscle pain ♦ gout ♦ other:

IMMUNE SYSTEM: frequent illness ♦ allergies ♦ swollen glands ♦ autoimmune disease ♦ HIV
rheumatoid arthritis ♦ Lyme Disease ♦ other:

NEUROLOGIC: headaches ♦ passing out ♦ stroke ♦ memory problems ♦ seizures ♦ confusion
muscle weakness ♦ lack of coordination ♦ difficulty walking ♦ decreased sensation ♦ tremors
attention problems ♦ nerve pain ♦ other:

PSYCHOLOGICAL: anxiety ♦ depression ♦ obsessive/compulsive disorder ♦ mania ♦ insomnia
stress ♦ sadness ♦ seasonal affective disorder ♦ suicidal thoughts ♦ other: