Clinical History Form

Date: ______________________________

Patient Name: ____ Date of Birth: ______________________

** An accurate medical, social and family history is very important for us to know in order to better assess your current medical health and influences on future health and well-being.*

Review of Systems

Please circle any of the following you are currently experiencing:

GENERAL	EYES	ENT	CARDIOVASCULAR	RESPIRATORY	GASTROINTESTINAL	GENITOURINARY
Fatigue	Blurred Vision	Hearing Problems	Chest Pain/Pressure	Cough—Acute	Abdominal pain	Painful Urination
Fever	Eye Drainage	Ear Ringing	Dizziness	Cough—Chronic	Diarrhea	Blood in Urine
Night Sweats	Eye Pain	Nosebleeds	Palpitations	Shortness of breath	Blood in stool	Frequent Urination
Weight Gain	Light Sensitivity	Hoarseness	Feet Swelling	Blood-Tinged Sputum	Nausea	Incontinence
Weight Loss	Double Vision	Sore Throat	Varicose Veins	Wheezing	Vomiting	Flank Pain

MUSCULOSKELETAL	SKIN/BREASTS	NEUROLOGICAL	HEMATOLOGIC/LYMPHATIC	ENDOCRINE	MALE	PSYCHOLOGIC
Joint Pain	Lesions/Moles	Fainting	Easy Bruising	Hair Loss	ED	Depression
Back Pain	Itching	Headaches	Excessive Bleeding	Heat/Cold Intol	Impotence	Anxiety
Joint Stiffness	Rash	Confusion/Memory Loss	Lymph Node Swelling	Excess Thirst		Severe Stress
Extremity Pain	Breast Mass	Numbness/Tingling	Anemia	Excess Sweat		Sleep Disturbance
Muscle Pain	Breast Tenderness	Seizure				

Allergies

☐ NONE ☐ MEDICATIONS ☐ LATEX ☐ FOOD ☐ OTHER

List Allergies and Reactions:

____ ____

____ ____

Prescription/Non-prescription Medications/Vitamins/Supplements

Medication Dose/Number Per Day	Medication Dose/Number Per Day	Medication Dose/Number Per Day
1. ______________________________	5. ______________________________	9. ______________________________
2. ______________________________	6. ______________________________	10. ______________________________
3. ______________________________	7. ______________________________	11 ______________________________
4. ______________________________	8. ______________________________	12. ______________________________

Supplements Current Use: Appetite Suppressant “Fat Burners” Multivitamin Creatine Ginseng SAM-e DHEA MaHuang Xenadrine Ephedrine Metabolife Other

Please list your preferred pharmacy: ____

Past Medical History

Please check if you have or have had:

☐ Arthritis ☐ Asthma ☐ Bleeding Difficulties ☐ Depression ☐ Diabetes Mellitus ☐ Emphysema ☐ Heart Disease

☐ Hepatitis ☐ High BP ☐ High Cholesterol ☐ HIV ☐ Insomnia ☐ Kidney Disease/Stones

☐ Migraines ☐ Osteoporosis ☐ Seizure Disorder ☐ STD ☐ Stroke ☐ TB ☐ Thyroid Disease

☐ Cancer (Type/Treatment) ____

Patient Name: ____ Date of Birth: ______________________

Assigned Sex *(Optional)*

Assigned Sex at Birth: Male Female

Gender Identity: Male Female Transsexual Male Transsexual Female Genderqueer, Neither Exclusively Male nor Female Other

Sexual Orientation: Heterosexual Homosexual Bisexual Other: ____

Gynecologic/Obstetric History

Date of last menstrual cycle: ____________ Age at onset of periods: ________ Age at onset of menopause: ________

Problems with menstrual cycles:

_____ None ______ Irregular frequency/duration ______ Dysmenorrhea ______ Heavy Bleeding ______ Other

Number of pregnancies: ________ Problems with pregnancies: ____

Number of live births: ________ Number of miscarriages: ________ Number of Abortions: ________

Current birth control: ___________________________________

Date of last pap smear: ________ History of abnormal pap smears? ☐ No ☐ Yes Abnormalities: ____________________________

Prevention

If over age 30, have you had your cholesterol level checked in the past 5 years? ☐ No ☐ Yes

Have you ever had a mammogram? ☐ No ☐ Yes If yes, date of last mammogram: ________________

Any abnormalities noted? ☐ No ☐ Yes ____

Have you ever had a colonoscopy? ☐ No ☐ Yes If yes, date of last colonoscopy: ______________________

Any abnormalities noted? ☐ No ☐ Yes ____

Have you ever had a bone density or DEXA test? ☐ No ☐ Yes If yes, date of last screening: ________________

Any abnormalities noted? ☐ No ☐ Yes ____

Date of last dental exam: ___________ Date of last eye exam: __________

Immunizations

☐ Tetanus/Yr ______________ ☐ Influenza/Yr ______________ ☐ Pneumonia/Yr ___________ ☐ Shingles/Yr ___________

☐ HPV vaccine: #1 ___________ #2 ___________ #3 ___________ ☐ Other/Yr ________________________________

Past Surgical History

SURGERY	DATE	SURGERY	DATE
________________________	____________________	________________________	__________________
________________________	____________________	________________________	__________________
________________________	____________________	________________________	__________________

Patient Name: ____ Date of Birth: _______________________

Family History

Illness Which Family Members? Illness Which Family Members?

Key: *MGM = Maternal Grandmother, MGF = Maternal Grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfather*

Cancer/Type? ____

Hypertension ____ Heart Disease ____

Diabetes ____ Stroke____

Mental Disease ____ Alcoholism____

Glaucoma ____ Bleeding Disorder____

Osteoporosis ____ Thyroid Disease____

Other ____

Father: Living / Deceased Age ____ Cause of Death ____________Brothers: # Alive ____ # Deceased____ Age____ Cause of Death ________

Mother: Living / Deceased Age ____ Cause of Death ____________Sisters: # Alive ____ # Deceased____ Age____ Cause of Death _________

Social History

Spiritual and/or Religious Preference (*optional*): ____

Education Background: High School College – 2 yr College – 4 yr Post-Graduate

Occupation: _______________________________________ Are you satisfied with your job? ___________________________

Marital Status: Single Married Separated Divorced Widowed

Number of Children: ___________________________

Who lives in your current household? ____

Do you feel safe at home? __________ If not, what makes you fearful? ____

Has anyone ever hit, kicked, pushed or verbally intimidated you? ____

Do you have any current major home, work, social or financial stressors affecting your life and/or well-being?

____

Do you have difficulty sleeping? __________ How many hours of sleep do you get each day? ______________________________

Hobbies/Recreation ____

Exercise: ☐ None Type of Exercise: ____

Frequency: Days per week/Time per session ____

Nutrition:

Are you happy with your current weight? Yes No If no, why not? ____

Are you currently on a special diet? Yes No If yes, what kind? ____

Do you eat 1-2 servings of fruit and 3-6 servings of vegetables each day? Yes No

How many glasses of water do you drink each day? __________

How would you rate your overall nutrition? Terrific Good Fair Poor Terrible

Tobacco/Alcohol/Caffeine

Tobacco Never smoked _____ Past Smoker: Cigarettes Quit Date ________ # Packs/Day ________

Cigars Quit Date ________ # Packs/Day ________

Current Smoker: ____ Every Day Smoker ____ Intermittent Smoker # Cigarettes/Cigars Per Day _________

Smokeless Tobacco: ____ Current Use # Cans/Pouches per Day ___________

Alcohol None _____ Frequency: ____ Rare ____ Social ____ Regular Use ____ Binges

Quantity: # Drinks per Day ______ # Drinks per Week ______ # Drinks per Month ______

Types of Alcohol: ____ Previous attempt to quit? ____________________

Caffeine None ___ Coffee Tea Soda # Servings per Day ____

Illicit Drug Use: Current Use: ____ No ____ Yes Type: ____

Prior Use: ____ No ____ Yes Type: ____ Quit Date: _______________