Clinical History Form

Date: ________________________________

Patient Name: ____ Date of Birth: ____________________

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

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) ____

Past Surgical History

SURGERY	DATE	SURGERY	DATE
____________________	__________________	____________________	________________
____________________	__________________	____________________	________________

Patient Name: ____

Social History

Occupation: ____________________________ Marital Status: Single Married Separated Divorced Widowed
Number of Children: ______________________
Hobbies/Recreation ________________________________
Exercise: ☐ None Type of Exercise: ____________________________ Frequency: # days per week ____________________

Family History

Illness	Which Family Members?	Illness	Which Family Members?
Cancer	___________________________	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 ________

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 Coffee Tea Soda # servings per day ____ None ____
Illicit Drug Use: Current Use: ____ No ____ Yes Type: ____
Prior Use: ____ No ____ Yes Type: ____ Quit Date: _____________

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
Date of last dental exam: ______________ eye exam: ____________

Immunizations

☐ Tetanus/Yr _______________ ☐ Influenza/Yr _______________ ☐ Pneumonia/Yr _____________ ☐ Shingles/Yr _____________
☐ HPV vaccine: #1 ______________ #2 ______________ #3 ______________ ☐ Other/Yr ______________________________________

Gynecologic/Obstetric History

Times Pregnant ________ Problems with pregnancy? ____
Problems with menstrual cycles:
_____ None ______ Irregular frequency/duration ______ Dysmenorrhea ______ Heavy Bleeding ______ Other
Current birth control: ____________ Age at onset of periods: _______________________
Age at onset of menopause: ________________________
Pap Smears: Never ______ Date of last pap ________________ History of abnormal paps? ☐ No ☐ Yes