

HEALTH HISTORY

Patient Name : _____ Birthdate : ___/___/___ Todays date: _____

Primary care physician: _____

Please list all medicines you are currently taking (including non-prescription drugs): _____

Goals for Treatment

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

Past Medical History such as cancer, diabetes, ear infections, eczema, accidents, injuries, mono infection surgeries, organ removals, etc...(please list dates of occurances)

Family History such as cancer, diabetes, heart disease, stroke, migraines, mental illness, or autoimmune condition (please state who in the family had these conditions)

Please list all allergies: _____

Habits such as alcohol, coffee, smoking, etc... _____

Exercise: _____

MEN ONLY: circle "yes" or "no" or leave blank

urination changes or difficulties...yes no Night urination...yes no Sexual dysfunction...yes no

WOMEN ONLY: circle "yes" or "no" or leave blank

Problems with menstrual cycle...yes no, If yes: _____

Vaginal itching or discharge...yes no Numbers of pregnancies: _____ Live births: _____

Hot flashes or night sweats...yes no If yes, how many per day? _____

To the best of my knowledge, the above information is correct. I understand that giving inaccurate information may harm my (my child's) health. It is my responsibility to inform the doctor of any changes in my or my child's medical status. I authorize the health care staff to perform necessary health care services.

Patient's signature: _____