PAST HEALTH HISTORY

In the PAST, have you had any problems with the following? Please check one box for each.

Yes	No		Describe	Yes	No		Describe
☐	☐	Blood pressure		☐	☐	Bladder/kidneys	
☐	☐	Blood sugar		☐	☐	Uterus/ovaries	
☐	☐	Anemia		☐	☐	Stomach	
☐	☐	Eyes/vision		☐	☐	Colon	
☐	☐	Ears/hearing		☐	☐	Skin disease	
☐	☐	Nose/sinuses		☐	☐	Arthritis	
☐	☐	Thyroid gland		☐	☐	Depression	
☐	☐	Heart		☐	☐	Anorexia/bulimia	
☐	☐	Lungs/breathing		☐	☐	Alcohol/drugs	
☐	☐	Liver/gall bladder		☐	☐	DES exposure	

Other: _____

CURRENT HEALTH HISTORY

How would you rate your general health?

☐Excellent ☐Good ☐Fair ☐Poor

Please indicate if you have any of the following problems CURRENTLY:

	YES	NO	Comments
Severe or unusual headaches	☐	☐	
Excessive/unusual fatigue	☐	☐	
Problems with your vision	☐	☐	
Hearing problems	☐	☐	
Problems with teeth or gums	☐	☐	
Difficulty chewing or swallowing	☐	☐	
Severe skin problems	☐	☐	
Unintended change in weight	☐	☐	
Chest pains or discomfort	☐	☐	
Shortness of breath/ chronic cough	☐	☐	
Stomach problems (pain or nausea)	☐	☐	
Pain in the abdomen	☐	☐	
Diarrhea or constipation	☐	☐	
Blood in bowel movements	☐	☐	
Breast pain, lump, or nipple discharge	☐	☐	
Painful or frequent urination	☐	☐	
Loss of urine	☐	☐	
Pain with sexual intercourse	☐	☐	
Spotting after sexual intercourse	☐	☐	
Palpitations of heart	☐	☐	
Seizures	☐	☐	
Muscle weakness	☐	☐	
New swelling of legs	☐	☐	

This past month, have you been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No

This past month, have you been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

Name:_____ Age:_____ Primary Care Provider:_____
How did you hear about our clinic?_____
What is the main reason for your visit today? _____

_____

List other health concerns or questions that you have:_____

_____

_____

Please list all the prescription, nonprescription, natural products, or vitamins you currently take:

Drug Name	Dosage	How taken

Are you allergic to any medications? ☐Yes ☐No

Drug Name	Type of Reaction

HEALTH HISTORY

List all of your major health problems (past and current) including surgeries, hospitalizations, injuries, fractures, etc.

Surgery/health problem	Date/Date of diagnosis	Hospital or treating M.D.

ROUTINE HEALTH CARE

<u>For women 40 and over</u>:
Date of your last mammogram:_____ Result:_____
Date of your last cholesterol blood test:_____ Result:_____
<u>For women 50 and over</u>:
Date of your last stool blood test:_____ Result:_____
Date of your last sigmoidoscopy or colonoscopy:_____ Result:_____
Have you received counselling regarding the pros and cons of hormone replacement therapy use?
☐ Yes ☐ No
Have you ever had a bone density screening exam (DEXA, bone ultrasound)? ☐ Yes ☐ No
If yes, what was the result? _____