

MEDICAL HISTORY

Today's Date _____

Chart # _____

Name _____

Birthdate _____ Last _____ Sex _____ First _____ Birthplace _____ Middle _____

ALLERGIES: NONE Bee Sting Poison Oak

Meds: _____ Foods: _____

Other: _____

CURRENT MEDICATIONS: NONE _____

CURRENT/CHRONIC MEDICAL CONDITIONS: NONE _____

PAST MEDICAL PROBLEMS (year or age): NONE _____

SURGERIES (year or age): NONE _____

SOCIAL HISTORY: College or School _____ Major _____
 Undergraduate Graduate Professional Other: _____

Are you currently employed? YES NO Occupation: _____

Marital Status: Single Married Separated/Divorced Widowed

Tobacco Usage: None Current use Prior use ___year started ___year quit
Amount/Type _____ Numbers of years _____

Alcohol Use: Beer / Wine / Spirits Occasional/Rarely Weekly Daily
(circle one) Estimated number of drinks per day/week _____
Are you or others you know concerned about your use of alcohol? YES NO

Drug/Nutrient Supplement use or abuse:
List all non-prescription medications you take regularly (include vitamins, antacids, pain meds, minerals, etc.) _____

Are you or others you know concerned about your use of non-prescription or illicit drugs? YES NO

Diet /Exercise: My current diet is: satisfactory unsatisfactory
Concerns: _____

My current exercise/activity level is: satisfactory unsatisfactory
Concerns: _____

My current weight is: satisfactory unsatisfactory
Concerns: _____

I have have not previously used diet or exercise to gain/lose weight.
I have have not previously used medication or supplements to gain/lose weight.

Contraception/Sexuality: I am currently using a reliable method of contraception.
 YES NO I am not in a sexually active relationship.
 If yes, please indicate **all** current methods:
 abstinence spermicide diaphragm condom
 cervical cap birth control pills Depo Provera injections
 Norplant IUD vasectomy tubal ligation
 If no, please indicate the statement that best describes your current reproductive preference/experience.
 My partner and I are currently trying to conceive.
 My partner and I are unable to conceive.
 I am in a sexually active relationship and have no need or choose not to use contraception.

FAMILY MEDICAL HISTORY: No knowledge of family medical history
 Race/Ethnicity (optional) _____

RELATION	AGE	HEALTH STATUS	IF DECEASED: Cause/Age at death
Father			
Mother			
Siblings			
Children			

Please indicate all conditions which apply to members of your family (brother, sister, father, mother, aunt, uncle, grandparent) and note relationship or additional concerns below:

- | | | |
|-----------------------------------------------------|-----------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> asthma/allergies | <input type="checkbox"/> headaches | <input type="checkbox"/> gallbladder |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> seizures/epilepsy | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> stroke | <input type="checkbox"/> kidney |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> thyroid disorder | <input type="checkbox"/> breast disease (benign) |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> breast disease (cancer) |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> chronic lung disease | <input type="checkbox"/> alcoholism/substance abuse |
| <input type="checkbox"/> bleeding/clotting disorder | <input type="checkbox"/> ulcers | <input type="checkbox"/> mental illness |

Other _____ Patient sign _____

SYSTEMS REVIEW: *(For clinician use only)*

Skin: _____
 Head/Eyes: _____
 Ears, Nose, Throat: _____
 Neck: _____
 Heart: _____
 Lungs: _____
 GI: _____
 GU: _____

Menstrual History: Age onset _____ Age menopause _____

Cycles: _____
 Symptoms: _____
 Medication use: _____

Bone/Joint: _____
 CNS: _____

History and Systems reviewed by: _____