MEDICAL HISTORY

Date: _____

Name: _____

Age: _____ Date of Birth: _____

Occupation: _____ Religion: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er)

Medical History: *Check box if you have ever had:*

- ☐ Alcoholism
- ☐ Allergies / hay fever
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chronic Bronchitis
- ☐ Circulatory Problems
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Drug Addiction
- ☐ Elevated Cholesterol
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fractures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Hepatitis A B C
- ☐ HIV positive
- ☐ Joint replacement (which joint?) _____
- ☐ Kidney infection
- ☐ Kidney Stones
- ☐ Liver, Gallbladder Disease
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Pancreatitis
- ☐ Panic Disorder
- ☐ Poor Blood Clotting
- ☐ Positive TB test
- ☐ Reflux
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Stroke
- ☐ Thrombophlebitis/ blood clots
- ☐ Tuberculosis
- ☐ Thyroid Disease: Hypothyroid Hyperthyroid Thyroid Nodule
- ☐ Ulcers
- ☐ Other: _____ _____

Family Medical History:

If any blood relative has ever had any of the following, check box and indicate which relative(s):

- ☐ Kidney Disease: _____
- ☐ Cancer: _____
  Type of Cancer: _____
- ☐ Chemical Dependency: _____
- ☐ Emphysema: _____
- ☐ Heart Attack/ Bypass/ Angioplasty: _____
- ☐ High Cholesterol: _____
- ☐ Stroke: _____
- ☐ Bleeding Tendency _____
- ☐ Liver Disease: _____
- ☐ Tuberculosis: _____
- ☐ Diabetes _____
- ☐ Migraine headaches: _____
- ☐ High Blood Pressure: _____
- ☐ Osteoporosis: _____
- ☐ Thyroid: _____

Please indicate the age(s) and health history for each of the following:

Father: _____

Mother: _____

Siblings: _____

Children: _____

Who was/is your previous primary care provider? (Please have copies of important records sent to us at 812-283-8299)
Name:_____
Phone:_____
Address:_____
Fax:_____

Please list all practitioners and mental health providers that you see.

Name:_____Phone:_____

Condition treated:_____

Name:_____Phone:_____

Condition treated:_____

Please list any complementary and/or alternative practitioners you see or have seen in the past (ie chiropractor, acupuncturist, naturopath, massage therapist, spiritual healer, etc.).
Approximate Dates Name of Therapist Type of Treatment Reason for Treatment Beneficial Experience?
of Treatment or Facility

_____ _____

_____ _____

How do you rate your over all health? Excellant Good Fair Poor
What are your expectations for today's visit?_____
What are your expectations for our work together in general?_____

_____
Prescriptions Medications You Are Currently Taking (both regularly scheduled and ones taken as needed)

Name of medicine Dose Frequency Condition being Treated
1)_____ 5) _____

2)_____ 6) _____

3)_____ 7) _____

4)_____ 8) _____

Non-Prescription Medications, Vitamines, Herbs, Supplements You are Currently Taking
Name Dose Frequency Condition being Treated
1)_____ 5) _____

2)_____ 6) _____

3)_____ 7) _____

4)_____ 8) _____

Allergies (to medications, food, environmental)

1)_____ 5) _____

2)_____ 6) _____

3)_____ 7) _____

4)_____ 8) _____

For Women Only:

Do you menstruate? _____If not, age period stopped:_____

Surgical or natural:_____

If yes, what was the first day of your last menstrual period?_____

Do you use birth control? Yes No If yes, what type? _____

Have you had gynecologic problems such as fibroids, endometriosis, abnormal PAPs?

_____

Have you had a mammogram? Yes No Have you had a colonoscopy? Y N

If you are greater than 60 years old, have you ever had a Bone Density Study? Y N

Have you had a colonoscopy? Y N

For Men Only:

If you are greater than 50 years old, have you had a Digital Rectal Exam of your Prostrate? Y N

Have you had a PSA blood test? Yes No Have you had a colonoscopy? Y N

Personal Health Assessment

What do you consider your ideal weight? _____

Are you trying to gain or lose weight right now? Y N If yes, how?_____

Have you ever had an eating disorder? Y N If yes, specify:_____

Do you think you eat a healthy diet in general? Yes No Do you follow a particular diet?_____

Describe a typical

Breakfast:_____

Lunch:_____

Dinner:_____

CommonSnacks:_____

How often do you exercise? Never Rarely 1-3 times a month 1-3 times per week 4-6 times/week

Average time per session:_____ How strenuous? Mild Moderate Vigorous

What kind of exercise do you do? _____

Symptoms?_____

Do you sleep well at night? Yes No How many hours do you sleep at night? _____

If no, do you: have trouble falling asleep wake up in the middle of the night wake up too early

How would you rate the current level of stress in your life? None Mild Moderate Severe

How well do you manage the stress in your life?Overwhelmed Not well Moderate Managing well

Do you have a spiritual frame-work - Anything that makes you feel connected to the larger world?

_____

Describe your spiritual or religious practices?

_____

Do you request prayer with your visits? Yes No

Name_____

Operations and/or Hospitalizations (Include Dental Surgery) - *List all below:*

_____

_____

_____

Have you ever smoked cigarettes? ☐ Yes ☐ No How many per day? _____
When did you start smoking? _____ If you used to smoke, have you quit? _____
When did you stop? _____ How long did you smoke (years)? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No Frequency/ Amount_____
Have you ever used illegal drugs? ☐ Yes ☐ No If yes, please list_____
Within the last six months, have you received a prescription for "pain" or "nerve" medication from another physician? ☐ Yes ☐ No If yes, please list. _____
Are you sexually active? ☐ Yes ☐ No

Caffeine: _____ cups of coffee/day _____ glasses of tea/day
_____ number of soft drinks/day _____ amount of chocolate/day

Give a brief description of your eating habits: _____

_____

_____

Exercise:

- ☐ Walk
- ☐ Run, jog, jump rope
- ☐ Weight lifting
- ☐ Swim
- ☐ Aerobics
- ☐ Belong to a gym

How often do you exercise?
_____

Duration of Exercise
_____

Stress:

What level of stress are you experiencing on a scale of 1 to 10? (*1 being the lowest*)
_____

What are the causes of stress?
(*Please check all that are appropriate.)*

- ☐ Job
- ☐ Home
- ☐ Finances
- ☐ Other _____

_____
_____

Are you wearing:

☐ Contact Lenses ☐ Dentures ☐ Partials ☐ Hearing Aid ☐ Medical devices
☐ Prosthesis ☐ Implants

☐ Other: _____

Name_____

Review of Systems: *Check box if you have any of the following symptoms.*

General
- ☐ Fever
- ☐ Weight Loss
- ☐ Swollen Glands
- ☐ Poor Appetite

HEENT
- ☐ Headache
- ☐ Recurrent Nose Bleeds
- ☐ Ear Pain
- ☐ Sores in Mouth
- ☐ Eye Pain
- ☐ Persistent Hoarseness

Skin
- ☐ Rash
- ☐ Changes in Moles
- ☐ Itching

Cardiopulmonary
- ☐ Irregular Heartbeat
- ☐ Palpitations
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Wheezing
- ☐ Leg Cramps
- ☐ Chronic Cough
- ☐ Swollen Ankles

GI
- ☐ Problems Swallowing
- ☐ Frequent Heartburn
- ☐ Diarrhea
- ☐ Changes in Bowel Habits
- ☐ Bloody Stools
- ☐ Constipation
- ☐ Black Tarry Stools
- ☐ Abdominal Pain

Kidney/ Bladder
- ☐ Blood in Urine
- ☐ Decreased in Force of Urination
- ☐ Painful Urination
- ☐ Incontinence

Neuro
- ☐ Faintness
- ☐ Dizziness

MusculoSkeletal
- ☐ Painful Joints
- ☐ Painful Muscles
- ☐ Swollen Joints
- ☐ Muscle Weakness
- ☐ Muscle Cramps
- ☐ Restless Legs

Endocrine
- ☐ Excessive Thirst
- ☐ Always Too Cold
- ☐ Always Too Hot

GU (Men)
- ☐ Lump in Testicles
- ☐ Sore on Penis
- ☐ Discharge from Penis
- ☐ Other:

_____

_____

_____

_____

GU (Women)
- ☐ Lump in Breast
- ☐ Vaginal Discharge
- ☐ Abnormal Vaginal Bleeding
- ☐ Hot Flashes
- ☐ Possibly Pregnant
- ☐ Nipple Discharge
- ☐ Change in Periods
- ☐ PMS, Irritability
- ☐ Cramps
- ☐ Vaginal Dryness
- ☐ Mood Swings
- ☐ Sleep Disturbances
- ☐ Menopausal
  When?_____
- ☐ Premenopausal
- ☐ Birth Control
  Type: _____
- ☐ History of Endometriosis
- ☐ History of Fibroids

Date of last Menstrual Period

_____

☐ Regular ☐ Irreg. ☐ Heavy

Date of Last Pap Smear

_____

☐ Normal ☐ Abnormal

Date of Last Mammogram

_____

☐ Other:

_____

_____

_____

Top Five Concerns:

1. _____
2. _____
3. _____
4. _____
5. _____