

COMPLETE HISTORY

Updated 9/29/05

Name: _____

Date: _____

Chief reason you are here today: _____

How long have you had this condition? _____

What prescription medications (if any) are you currently taking? _____

Are you currently taking Botanicals/Herbals? (Please attach list if lengthy.) _____

Are you currently taking any supplements? (Vitamins, etc.)- (Please attach list if lengthy.) _____

Are you currently using any alternative or complementary medicine?

- | | | | |
|--------------------------------------|--|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Guided Imagery | <input type="checkbox"/> Hypnosis | <input type="checkbox"/> Prayer |
| <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Herbs/Supplements | <input type="checkbox"/> Meditation | <input type="checkbox"/> Other _____ |

Please list ALL surgeries you have had (List Surgery/Date/Hospital).

Have you ever had a serious illness? (List illness/Date)

When was your last complete physical exam? _____

Name and location of Physician: _____

Women: When was your last pelvic exam? _____ Pap smear? _____ Mammogram? _____

Men: When was your last prostate exam (digital)? _____ Last PSA (blood test)? _____

When was your last eye exam? _____ By whom? _____ Ophthalmologist/Optometrlist?

When was your last dental check-up? _____ By whom? _____

When was your last chest x-ray? _____

Immunizations (including date last given, if known):

- | | | |
|-------------------|------------------|------------------------|
| DPT or DT _____ | Measles _____ | Rubella _____ |
| Hepatitis A _____ | Mumps _____ | TB Test & Result _____ |
| Hepatitis B _____ | Oral Polio _____ | |

FAMILY HISTORY:

Are your parents living? **Mother** Living, Age? _____ **Father** Living, Age? _____

If deceased, from what cause? **Mother** Cause? Age? _____ **Father** Cause? Age? _____

Have any member of your family had the following?

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental/emotional illness | <input type="checkbox"/> Wt. problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Migraine | <input type="checkbox"/> Cancer (list) _____ |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Intestinal/colon | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other _____ |

SOCIAL HISTORY:

What do you do for fun?

- | | | | | |
|---|--------------------------------------|---------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> art (paint/sculpt) | <input type="checkbox"/> family time | <input type="checkbox"/> listen music | <input type="checkbox"/> sleep | <input type="checkbox"/> woodwork |
| <input type="checkbox"/> church | <input type="checkbox"/> fish | <input type="checkbox"/> party | <input type="checkbox"/> socialize | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> crafts | <input type="checkbox"/> garden | <input type="checkbox"/> read | <input type="checkbox"/> sports | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> exercise | <input type="checkbox"/> hunt | <input type="checkbox"/> shopping | <input type="checkbox"/> travel | <input type="checkbox"/> other _____ |

If you had all the money in the world, what would you want to do with it? _____

What is your occupation? _____ Are you happy at your current job? _____

How much coffee do you drink daily? _____ Tea? _____ Sodas? _____

How many hours of uninterrupted sleep do you get at night? _____ Is this enough? _____

What type of sleeping aid (if any) do you use and how often? _____

What best describes your use of substances? Complete the table below.

Substance\ Use	Have you ever used?	How much/How long?	Do you still use?	How much/How often?
Cigarettes	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ pks/day X ____ yrs	<input type="checkbox"/> Yes <input type="checkbox"/> No	____ pks/day X ____ yrs
Tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____/day X ____ yrs	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____/day X ____ yrs
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	____drinks/day or week ____drinks/weekend X ____ yrs	<input type="checkbox"/> Yes <input type="checkbox"/> No	____drinks/day or week ____drinks/weekend X ____ yrs
Pain Meds (Rx)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name/dose:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name/dose:
Injection Drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever been or are you currently addicted to prescription OR non-prescription drugs? _____

If so, which? _____

When was the last time you had more than five drinks in one day? _____

Have you ever felt the need to cut back on drinking alcohol? _____

Have you ever felt guilty about drinking? _____

Have you ever felt you needed a drink first thing in the morning ("eye opener")? _____

Have you ever been attacked or threatened? _____ Witnessed violent acts/events? _____

Have you ever been abused emotionally? _____ Physically? _____ Sexually? _____

Do you feel safe in your home? If not, explain: _____

Did you grow up with an alcohol/drug abuser? _____ Some one who was incarcerated? _____

Did you grow up primarily with a single parent? _____ With emotional/physical neglect? _____

Did you grow up with someone who is chronically depressed, suicidal or mentally ill? _____

If yes to any above 10 questions, please explain. _____

MENTAL HEALTH HISTORY:

Over the past 2 weeks, have you felt little interest/pleasure in activities you normally enjoy? Explain:

Have you ever felt down, depressed, or hopeless? _____

Do you now, or have you ever, seen a psychiatrist, psychologist, or counselor? _____
 If yes, for how long? _____ Name and location of therapist: _____
 Primary reasons for therapy? _____
 Please list any psychiatric medication you have taken or are currently taking: _____

Have you ever been hospitalized for a psychiatric illness? _____
 Explain: _____

NUTRITION AND DIET

Do you consider your weight to be appropriate? _____ Explain: _____
 What is the most you have ever weighed as an adult? _____
 What diets or prescriptions have you tried for weight losses that have been successful? _____
 Any diets or prescriptions that have been unsuccessful? _____
 Have you ever taken laxatives to lose weight? _____ Induced vomiting after a meal? _____
 How many meals a day do you usually eat? _____

My diet is best defined as Regular (animal/plant) vegetarian vegan other _____

Foods frequently eaten	Dairy	Fish	Fruit	Poultry	Red Meat	Vegetables	Whole Grains	Soy	Fast food
Never									
Weekly									
More than once weekly									
Daily									
More than once daily									

What kind of food do you snack on? _____ How often? _____

EXERCISE:

Do you exercise regularly (2-3 times) weekly? _____ For how long? _____ /min or hrs each session _____
 What types of exercise do you do regularly?
 aerobics hiking running team sports other _____
 cycling kayaking skiing walking other _____
 elliptical machine pilates stair climber weight training other _____
 gardening rowing swimming yoga other _____
 Do you do stretching before and after strenuous exercise? _____

TRAVEL:

Have you ever traveled outside the continental U.S.? _____ If so, where and when? _____
 Did you ever become ill while traveling outside the U.S.? _____
 Explain: _____

STRESS:

Do you consider yourself to be under a lot of stress? _____ Explain: _____
 Are you a tense or nervous person? _____
 Have you ever had to cope with an unusually high amount of stress? _____
 Explain: _____
 How do you handle stress? _____ How do you relax? _____
 How do you make yourself feel better? _____

How do you express your spirituality? _____
 Do you have any nervous habits? Explain: _____
 Have you ever suffered from phobias? Explain: _____
 Have you ever experienced a severe accident or natural disaster? Explain: _____
 Many people are troubled by frightening childhood events. Do you have this problem? _____

SEXUAL HEALTH:

Are you in a relationship? _____ For how long? _____ Are you married? _____
 Are you sexually active? _____ Do you have a partner or partners? _____ How many? _____
 Have you ever been sexually active with a man, women or both? _____
 What is your sexual preference? (man, woman or both) _____
 At what age did you first have sexual intercourse? _____
 Have you ever had a sexually transmitted infection (STI)? _____
 If yes, list the STI type and the treatment used? _____
 Have you ever been diagnosed with genital herpes? _____ When? _____
 Have you had an AIDS screening test? _____ Date of your last AIDS test? _____ Result? _____
 Have you ever been tested for hepatitis? _____ When? _____ Result? _____ If pos? Type? _____

Men: Do you regularly check for testicular lumps? _____ Date of last PSA _____

Women: Your age when you got your first period? _____ Are your periods regular? _____

How long is your monthly cycle? ___/days How long is your flow? ___/days Do ever have PMS? _____

Are you currently using birth control? _____ What method(s)? _____

Have you ever taken birth control pills? _____ When? _____ How long? _____

Have you ever used IUD? _____ When? _____ How long? _____

Have you ever been pregnant? _____ How many times? _____ Difficulty getting pregnant? _____

Any miscarriages/abortions/stillbirths (number of each)? _____

How many children do you currently have? _____ Any complications with your pregnancies? _____

Explain: _____

Have you or your mother ever taken DES (diethylstilbestrol)? _____

Have you had any lumps or other problems in your breasts? _____

Do you check for breast lumps regularly? _____ Date of last Mammogram: _____

REVIEW OF SYSTEMS: Please list any problems you have had in the following areas and dates of occurrence:

Skin, scalp & nails: _____

Head/brain: _____

Eyes, ears, nose, mouth & throat: _____

Lungs/chest: _____

Heart/vascular system: _____

Stomachic/intestine/colon: _____

Back/Spine: _____

Extremities (arms, legs, joints): _____

Nerves/sensation: _____

Hormones/glands: _____

Bladder/kidneys/genitalia: _____