COMPLETE HISTORY

Updated 12/27/05

Name: _____ **Date:** _____

Date of Birth:_____**Age:** ____ **Allergies to medications:** _____

Chief reason for your visit today: _____

_____

How long have you had this condition? _____

What prescription medications (if any) are you currently taking? (Please attach list if lengthy.)_____

_____

_____

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?

☐ Acupuncture ☐ Guided Imagery ☐ Hypnosis ☐ Prayer

☐ Biofeedback ☐ Herbs/Supplements ☐ Meditation ☐ 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/Optometrist?

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?

☐ Alcoholism	☐ Heart disease	☐ Mental/emotional illness	☐ Wt. problems
☐ Arthritis	☐ High blood pressure	☐ Migraine	☐ Cancer (list)_____
☐ Bleeding disorders	☐ Intestinal/colon	☐ Stroke	☐ Other_____
☐ Diabetes	☐ Kidney disease	☐ Thyroid	☐ Other_____
☐ Epilepsy	☐ Low blood sugar	☐ Ulcers	☐ Other_____

SOCIAL HISTORY:

What do you do for fun/hobbies?

☐ art (paint/sculpt)	☐ family time	☐ listen music	☐ sleep	☐ woodwork
☐ church	☐ fish	☐ party	☐ socialize	☐ other _____
☐ crafts	☐ garden	☐ read	☐ sports	☐ other _____
☐ exercise	☐ hunt	☐ shopping	☐ travel	☐ other _____

How do you express your spirituality? _____

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	☐ Yes ☐ No	____ pks/day X ___ yrs	☐ Yes ☐ No	____ pks/day X ___ yrs
Tobacco	☐ Yes ☐ No	_____/day X ___ yrs	☐ Yes ☐ No	_____/day X ___ yrs
Alcohol	☐ Yes ☐ No	___drinks/day or week ___drinks/weekend X ___ yrs	☐ Yes ☐ No	___drinks/day or week ___drinks/weekend X ___ yrs
Pain Meds (Rx)	☐ Yes ☐ No	Name/dose:	☐ Yes ☐ No	Name/dose:
Injection Drugs	☐ Yes ☐ No		☐ Yes ☐ 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? _____Someone 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. _____

_____

Do you talk on your cell phone while driving?_____Text while driving?_____

MENTAL HEALTH HISTORY:

Do you think you are under a lot of stress? (circle) ☐ ☐ ☐ **now / often / always** Explain:_____

_____

What is the major source of your stress?_____

_____

How do you handle stress? _____

What do you do to relax?_____ Have you ever had relaxation training?_____

Are you a tense or nervous person? _____Do you often think of your worries/fears?_____

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? _____

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? _____

Have you ever felt that life is not worth living? _____

Have you ever felt like you wanted to kill yourself? _____

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 or diagnosis?_____

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: _____

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 you get 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: _____

_____

Stomach/intestine/colon: _____

Back/Spine: _____

Extremities (arms, legs, joints): _____

Nerves/sensation: _____

Hormones/glands: _____

Bladder/kidneys/genitalia: _____

_____