PATIENT PERSONAL HEALTH HISTORY

CONFIDENTIAL for Preventive Medical Center of Marin

Please Print Date: _______________

I. GENERAL INFORMATION

Name:____ Phone: (_____)____________________

Street Address: (mailing) __________________________________ Birth date: ___/______/______

City, State, Zip: ____ Birthplace: _________________

Work/Occupation: ____

What was your general health as a child? ____

Approximate date of last medical exam: _______/______/______

Are you presently under a doctor's care? ______________ Name: ____________________________

For what?: ____

Do you have any allergies to medicines, foods, or environmental exposures? __________________

To what? ____

Do you currently take any medications or nutritional/herbal supplements? ___________________

Rx or OTC Meds? ____

Natural Supps? ____

____

Any other healers, helpers, or therapies with which you are involved? _________________ If yes, who and for what?____

II. CURRENT FOCUS & PAST EVENTS

Why have you come to the Preventive Medical Center of Marin? ___________________________

____

Were you referred? __________________ If yes, by whom? __________________________________

What is your primary concern? ____

____

____

List any other current symptoms or problems: ____

____

____

Have you had any operations? _______________ If so, what and when (year)? _______________

____

Have you had any major injuries/accidents? ___________ If so, what and when (year)? _________

____

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CURRENT FOCUS & PAST EVENTS continued

Have you had any major illnesses or been hospitalized for any reason? ______________________

If so, what and when (year)? ____

____

III. CHECKLIST FOR PRESENT OR ONGOING SYMPTOMS

Check any ailment/problem you currently have, or have had in the past 2 years.

Mark 2 checks if ailment occurs often; and three checks if it is a regular difficulty.

_______ weight change	_______ mouth problems	_______ urinary problems
_______ fatigue	_______ coated tongue	_______ back pains
_______ confusion/fogginess	_______ bad breath	_______ neck pains
_______ nervousness	_______ sore throats	_______ cold hands/feet
_______ skin rashes	_______ cough	_______ leg swelling/edema
_______ hay fever/allergies	_______ difficulty breathing	_______ bone or joint pains
_______ headaches	_______ heart palpitations	_______ joint swelling
_______ insomnia	_______ chest pains	_______ menstrual problems
_______ dizziness	_______ breast lumps or pains	_______ irregular bowels
_______ ringing in ears	_______ abdominal pain	_______ number BMs/day
_______ indigestion	_______ gas or bloating	_______ bloody or black stools
_______ earaches	_______ constipation	_______ sexual desire changes
_______ visual changes	_______ diarrhea	_______ mucus problems
_______ sinus infections	_______ hemorrhoids	_______ poor endurance

IV. PAST PROBLEMS

Please check any ailment you have had. Indicate approximate year(s) of occurrence.

_______ anemia	_______ high blood pressure	_______ kidney infection
_______ allergies/hay fever	_______ low blood pressure	_______ kidney stones
_______ asthma	_______ irregular heart beats	_______ gout
_______ hives	_______ heart attack	_______ arthritis
_______ hypoglycemia	_______ cancer	_______ ulcer
_______ parasites	_______ migraine headache	_______ colitis
_______ eczema	_______ mononucleosis	_______ obesity
_______ drug reaction	_______ mental breakdown	_______ chronic fatigue
_______ psoriasis	_______ hepatitis	_______ candida problems

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V. FEMALE CONCERNS

Date of last menstrual period? ________/______/______ Are your periods regular? ___________

How many days is your flow? _______________ Is it heavy?_______________________________

Do you have painful or symptomatic periods? _________ If so, please describe. _______________

____

When was your last pap test? ________/______/______ Ever an abnormal one? _____________

Number of pregnancies: _____________ Deliveries ________________ Any problems? ______

____

Do you practice birth control? ________ What form? ____________________________________

Have you used BC pills: ____________________ How many years? ________________________

VI. FAMILY HISTORY

List birth dates and health status of immediate family. Write A/W (if alive and well), or write in any chronic illness(es) they have. If deceased, mark D and indicate the cause

Family Member	Birthdate	Health Status
Mother	_____________	____
Father	_____________	____

NOTE: Circle S for sister and B for brother

S/B	_____________	____
S/B	_____________	____
S/B	_____________	____

Do any of these illnesses run in your family? If so, please check and note above.

_______ diabetes	_______ asthma	_______ mental illness
_______ high blood pressure	_______ gout	_______ thyroid problems
_______ heart disease	_______ cancer	_______ obesity

LIST INFORMATION ON YOUR CHILDREN AND RELATIONSHIP:

Children's Names:	M or F	Birth date
_________________________________	_______	__________________________
_________________________________	_______	__________________________
_________________________________	_______	__________________________

Current Partner:	Dates	Status
_________________________________	_______	__________________________

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VII. DIET AND EXERCISE

DIET

Do you have a good appetite? ________________ Good eating habits? ________________________

Eat a good diet? _____________ Do you crave any foods? _____________ What? ______________

____

What foods do you eat most often? ____

Do you chew your food well? _________ Do you practice healthy hygiene? __________________

Write servings per day you eat from these basic food categories. (Note per week if more appropriate.)

_______ fruits/juice _______ grains/breads _______ dairy products

_______ vegetables _______ nuts, beans, seeds _______ animal proteins

Animal Proteins (Servings/week)

_______ beef/lamb _______ poultry _______ fish _______ lunchmeat

What foods with chemical additives do you eat? ____

____

What percent of your diet comes from restaurants? _____ from home-prepared foods? _________

How frequently do you eat the following items on a daily or weekly basis? (1/W=once a week)

______________ Fried foods ______________ Wine

______________ White sugar or corn syrup ______________ Beer

______________ Food Additives ______________ Hard liquor

______________ Soft drinks/ Soda ______________ Rec. Drugs

______________ Coffee ______________ Nicotine

EXERCISE

Do you enjoy exercise? ______________ Mild? ______________ Strenuous? _________________

How often do you exercise weekly? ____

Do you perspire/sweat easily? ________________ Do you sauna or steam often? ______________

Do you often feel fatigued after you exercise? ____

List exercise and frequency:

___________________________________ ___________________________________

___________________________________ ___________________________________

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VIII. GENERAL QUESTIONS

Do you have a garden? _______________ Vegetable __________________ Flower _____________

Do you have any pets? _______________ What kind? ________________________________

Are you able to express your emotions/feelings? ___________________________________

Is there any of these that you feel predominantly?______________ If so, which ones?

_______ sadness _______ anger _______ fear

_______ worry _______ depression _______ anxiety/panic

Are you often too emotional or too unemotional? __________________________________

Is there much stress in your life? ____

If so, what does it surround? i.e., family, work, finances, relationships, etc. ___________________

____

Do you sleep well? __________________ How many hours a night? __________________

Are you happy with your general energy level? ____________________________________

Is there a low point in your day? _____________________ When? ____________________

Are there climates you especially don't like? What and why? _________________________

What is your favorite season? ________ Why? _____________________________________

With whom do you live? ____

What is your work? ____

Do you enjoy your career? ____

What are your hobbies/pleasures? ____

____

How do you feel about yourself? ____

____

About your life? ____

____

Any questions you have for the doctor? ____

____

____

Do you have any special needs from the Medical Center? ____________________________

____

____

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