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## CONFIDENTIAL PATIENT CASE HISTORY

**Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.**

### PERSONAL INFORMATION

| First Name | M.I. | Last Name | No | Date of Birth | Age |
|---|---|---|---|---|---|
| Gender ☐ M ☐ F | | Social Security # | Phone | | Fax |
| Address | | | E-mail | | |
| Occupation | | | Employer | | |
| Who referred you to us? | | | How else did you hear about us? | | |
| Emergency Contact | | | Relationship | | Phone |

### CURRENT HEALTH STATUS

| Primary Complaint(s) | Allergies |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| Current Medications | Current Supplements |
| | |
| | |
| | |
| | |
| | |
| Tobacco Smoking | Alcohol (Type of alcohol, amount per week) |
| ☐ Yes ☐ No | |

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## HOSPITAL ADMISSIONS & SURGERIES

| Reason | Year |
|---|---|
| | |
| | |
| | |
| | |

## FAMILY HISTORY

Select the illnesses that have affected members of your immediate family only (parents, siblings, and grandparents).

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Glaucoma | ☐ Heart Disease | ☐ Alcoholism |
| ☐ Asthma | ☐ Bleeds Easily | ☐ Hypertension | ☐ Osteoporosis |
| ☐ Epilepsy | ☐ Hepatitis | ☐ Alzheimer's Disease | ☐ Diabetes |
| ☐ Stroke | ☐ Thyroid Disorder | ☐ Breast Cancer | ☐ Prostate Cancer |
| ☐ Lipid Disorder | ☐ Mental Illness | ☐ Ovarian Cancer | ☐ Testicular Cancer |
| ☐ Hip Fracture | ☐ Arthritis | ☐ Uterine Cancer | ☐ Other Cancer |

## ILLNESS & SYMPTOMS

Select the illnesses and/or symptoms you have experienced in the past, or are currently experiencing.

| **GENERAL** | **NOW** | **PAST** | **THROAT** | **NOW** | **PAST** | **GASTRO-INTESTINAL** | **NOW** | **PAST** |
|---|---|---|---|---|---|---|---|---|
| Weakness | ☐ N | ☐ P | Soreness | ☐ N | ☐ P | Abdominal Pain | ☐ N | ☐ P |
| Fatigue | ☐ N | ☐ P | Bad Tonsils | ☐ N | ☐ P | Nausea | ☐ N | ☐ P |
| Fever | ☐ N | ☐ P | Hoarseness | ☐ N | ☐ P | Bloated | ☐ N | ☐ P |
| Chills | ☐ N | ☐ P | Pain | ☐ N | ☐ P | Belching | ☐ N | ☐ P |
| Night Sweats | ☐ N | ☐ P | Trouble Swallowing | ☐ N | ☐ P | Heartburn | ☐ N | ☐ P |
| Fainting | ☐ N | ☐ P | Recurrent Infections | ☐ N | ☐ P | Indigestion | ☐ N | ☐ P |
| **SKIN** | | | **NECK** | | | Irregular Bowel Habits | ☐ N | ☐ P |
| Color Changes | ☐ N | ☐ P | Neck Enlargement | ☐ N | ☐ P | Constipation | ☐ N | ☐ P |
| Nail Changes | ☐ N | ☐ P | Stiff Neck | ☐ N | ☐ P | Dirrhea | ☐ N | ☐ P |
| Hair Changes | ☐ N | ☐ P | Soreness | ☐ N | ☐ P | Gas | ☐ N | ☐ P |
| Moles | ☐ N | ☐ P | Lumps | ☐ N | ☐ P | Hemorrhoids | ☐ N | ☐ P |
| Rashes | ☐ N | ☐ P | Masses | ☐ N | ☐ P | Poor Appetite | ☐ N | ☐ P |
| Sores | ☐ N | ☐ P | **BREASTS** | ☐ N | ☐ P | Food Intolerance | ☐ N | ☐ P |
| Weakness | ☐ N | ☐ P | Discharge | ☐ N | ☐ P | Bloody Stools | ☐ N | ☐ P |
| **HEAD** | ☐ N | ☐ P | Lumps | ☐ N | ☐ P | Black Stools | ☐ N | ☐ P |
| Headaches | ☐ N | ☐ P | Pain | ☐ N | ☐ P | **GENITO-URINARY** | | |
| Injuries | ☐ N | ☐ P | Bleeding | ☐ N | ☐ P | Urgency | ☐ N | ☐ P |
| Bumps | ☐ N | ☐ P | Nipple Changes | ☐ N | ☐ P | Incontinence | ☐ N | ☐ P |
| Last Eye Exam | ☐ N | ☐ P | Skin Changes | ☐ N | ☐ P | Straining | ☐ N | ☐ P |
| Glasses | ☐ N | ☐ P | Bloated | ☐ N | ☐ P | Back Pain | ☐ N | ☐ P |
| Contacts | ☐ N | ☐ P | **LUNGS** | ☐ N | ☐ P | Frequent Voiding | ☐ N | ☐ P |
| Cataracts | ☐ N | ☐ P | Cough | ☐ N | ☐ P | Stones | ☐ N | ☐ P |
| | | | Phlegm | ☐ N | ☐ P | Burning | ☐ N | ☐ P |

| **EARS** | **NOW** | **PAST** | **LUNGS** | **NOW** | **PAST** | **GENITO-URINARY** | **NOW** | **PAST** |
|---|---|---|---|---|---|---|---|---|
| Hard of Hearing | ☐ N | ☐ P | Blood | ☐ N | ☐ P | Bed Wetting | ☐ N | ☐ P |

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|---|---|---|---|---|---|---|---|---|
| Deafness | ☐ N | ☐ P | Short of Breath | ☐ N | ☐ P | Small Stream | ☐ N | ☐ P |
| Ringing | ☐ N | ☐ P | Wheezing | ☐ N | ☐ P | Discharge | ☐ N | ☐ P |
| Discharge | ☐ N | ☐ P | Pain | ☐ N | ☐ P | Impotence | ☐ N | ☐ P |
| Earache | ☐ N | ☐ P | Congestion | ☐ N | ☐ P | Dribbling | ☐ N | ☐ P |
| Itching | ☐ N | ☐ P | Inhalant Exposure | | | Cloudy Urine | ☐ P | ☐ P |
| Dizziness | ☐ N | ☐ P | **HEART** | | | Urine Color | | |
| Room Spins | ☐ N | ☐ P | Murmur | ☐ N | ☐ P | Spotting Between Periods | ☐ N | ☐ P |
| **NOSE** | | | Palpitations | ☐ N | ☐ P | Menstrual Cramps | ☐ N | ☐ P |
| Decreased Smell | ☐ N | ☐ P | Rapid Heartbeat | ☐ N | ☐ P | Discharge | ☐ N | ☐ P |
| Bleeding | ☐ N | ☐ P | Swollen Extremities | ☐ N | ☐ P | Itching | ☐ N | ☐ P |
| Pain | ☐ N | ☐ P | Cold Extremities | ☐ N | ☐ P | Painful Intercourse | ☐ N | ☐ P |
| Discharge | ☐ N | ☐ P | Chest Pain/Pressure | ☐ N | ☐ P | Irregular Periods | ☐ N | ☐ P |
| Obstruction | ☐ N | ☐ P | Varicose Veins | ☐ N | ☐ P | Hot Flashes | ☐ N | ☐ P |
| Post Nasal Drip | ☐ N | ☐ P | Blood Clots | ☐ N | ☐ P | Contraception Type | | |
| Deviated Septum | ☐ N | ☐ P | Blue Extremities | ☐ N | ☐ P | Age at First Period | | |
| Runny Nose | ☐ N | ☐ P | **BLOOD** | | | Duration of Cycle | | |
| Sinus Congestion | ☐ N | ☐ P | Anemia | ☐ N | ☐ P | Duration of Flow | | |
| **MOUTH** | | | Low Blood Iron | ☐ N | ☐ P | No. of Pregnancies | | |
| Bleeding Gums | ☐ N | ☐ P | Easy Bruising | ☐ N | ☐ P | No. of Births | | |
| Sores | ☐ N | ☐ P | Easy Bleeding | ☐ N | ☐ P | No. of Miscarriages | | |
| Dental Problems | ☐ N | ☐ P | Swollen Nodes | ☐ N | ☐ P | No. of Abortions | | |
| Bad Breath | ☐ N | ☐ P | Painful Nodes | ☐ N | ☐ P | Menstrual Flow | ☐ Heavy ☐ Mod ☐ Light | |
| Loss of Taste | ☐ N | ☐ P | Sugar in Blood | ☐ N | ☐ P | Last Period | | |
| Dry Mouth | ☐ N | ☐ P | Red Spots | ☐ N | ☐ P | Last Pap Smear | | |
| Ulcers | ☐ N | ☐ P | | ☐ N | ☐ P | Last Vaginal Exam | | |
| Blisters | ☐ N | ☐ P | | ☐ N | ☐ P | Last Mammogram | | |
| | | | | | | Last Prostate Exam | | |
| **NEUROLOGIC** | | | **PSYCHIATRIC** | | | **MUSCULO-SKELETAL** | | |
| Seizures | ☐ N | ☐ P | Hyperventilation | ☐ N | ☐ P | Muscle Pain | ☐ N | ☐ P |
| Vertigo | ☐ N | ☐ P | Insecurity | ☐ N | ☐ P | Muscle Weakness | ☐ N | ☐ P |
| Dizziness | ☐ N | ☐ P | Depression | ☐ N | ☐ P | Muscle Cramps | ☐ N | ☐ P |
| Hand Trembling | ☐ N | ☐ P | Troubled Sleep | ☐ N | ☐ P | Muscle Twitching | ☐ N | ☐ P |
| Loss of Sensation | ☐ N | ☐ P | Irritable | ☐ N | ☐ P | Joint Stiffness | ☐ N | ☐ P |
| Incoordination | ☐ N | ☐ P | Undecidedness | ☐ N | ☐ P | Joint Pain | ☐ N | ☐ P |
| Loss of Facial | ☐ N | ☐ P | Timid | ☐ N | ☐ P | | | |
| Weak Grip | ☐ N | ☐ P | Hallucinations | ☐ N | ☐ P | | | |
| Paralysis | ☐ N | ☐ P | Loss of Memory | ☐ N | ☐ P | | | |
| Difficulty Speech | ☐ N | ☐ P | Alcoholism | ☐ N | ☐ P | | | |
| Tingling | ☐ N | ☐ P | Drug Addiction | ☐ N | ☐ P | | | |
| Loss of Memory | ☐ N | ☐ P | Drug Dependent | ☐ N | ☐ P | | | |
| Numbness | ☐ N | ☐ P | Suicidal Thoughts | ☐ N | ☐ P | | | |
| | | | Extreme Worry | ☐ N | ☐ P | | | |
| | | | Sexual Problems | ☐ N | ☐ P | | | |
| **ENDOCRINE** | | | | | | | | |
| Weight Loss | ☐ N | ☐ P | | | | | | |
| Weight Gain | ☐ N | ☐ P | | | | | | |
| Extremely Thin | ☐ N | ☐ P | | | | | | |
| Heat Intolerance | ☐ N | ☐ P | | | | | | |
| Cold Intolerance | ☐ N | ☐ P | | | | | | |
| Hair Changes | ☐ N | ☐ P | | | | | | |
| Breast Changes | ☐ N | ☐ P | | | | | | |

| | | |
|---|---|---|
| **IMMUNIZATION / VACCINATION** | | **PAST MEDICAL HISTORY. Check only the ones you have had in the past** |

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|---|---|---|---|---|---|---|---|
| DPT | Y ☐ | | Hay Fever | Y ☐ | | Parasites | Y ☐ |
| Mumps | Y ☐ | | Mumps | Y ☐ | | Epilepsy | Y ☐ |
| Smallpox | Y ☐ | | Rheumatic Fever | Y ☐ | | Paralysis | Y ☐ |
| Typhoid | Y ☐ | | Allergies | Y ☐ | | Polio | Y ☐ |
| Tetanus | Y ☐ | | Angina | Y ☐ | | Mental Illness | Y ☐ |
| Measles | Y ☐ | | Cancer | Y ☐ | | Alcoholism | Y ☐ |
| Pneumococcal | Y ☐ | | Tumor | Y ☐ | | Depression | Y ☐ |
| Influenza | Y ☐ | | Blood Disease | Y ☐ | | Nervous Breakdown | Y ☐ |
| Polio | Y ☐ | | Leukemia | Y ☐ | | Migraine | Y ☐ |
| MMR | Y ☐ | | Heart Trouble | Y ☐ | | Gout | Y ☐ |
| | | | Varicose Veins | Y ☐ | | Hemorrhoids | Y ☐ |
| | | | Phlebitis | Y ☐ | | Prostate Problems | Y ☐ |
| | | | Hypertension | Y ☐ | | Sexual Problems | Y ☐ |
| | | | Stroke | Y ☐ | | Gonorrhea | Y ☐ |
| **BLOOD TYPE** | | | Ulcers | Y ☐ | | Syphilis | Y ☐ |
| A+ ☐ | A- ☐ | | Jaundice | Y ☐ | | Diabetes | Y ☐ |
| B+ ☐ | B- ☐ | | Skin Trouble | Y ☐ | | Bladder Trouble | Y ☐ |
| AB+ ☐ | AB- ☐ | | Gallstones | Y ☐ | | Kidney Stones | Y ☐ |
| O+ ☐ | O- ☐ | | Liver Trouble | Y ☐ | | Kidney Infections | Y ☐ |
| Other | | | Hepatitis | Y ☐ | | Dysentery | Y ☐ |

**BLOOD TRANSFUSIONS**
Date_____
Date_____
Date_____
Date_____

**Date of Last Chest X-Ray** _____☐ Normal ☐ Abnormal
**Last TB Skin Test** _____☐ Normal ☐ Abnormal
**Allergies:** _____
_____
_____
_____

## BODY COMPOSITION

| |
|---|
| Do you use weight gain/loss supplements? If YES, please explain. |
| List any food intolerances. |

## EXERCISE

| Use the following chart to rate the exercises you list below. | |
|---|---|
| Frequency | The number of times per week you engage in this exercise |
| Intensity | 1 = Light aerobic exercise (normal walking, golfing): # _____ times/week<br>2 = Low-moderate aerobic and sports activities (recreational volleyball, moderate speed walking): # _____ times/week<br>3 = Moderate aerobic activities (normal bike riding, jogging, low impact aerobics): # _____ times/week<br>4 = Moderately high aerobic activities and intermittent sports activities (tennis, stair-stepping, squash): # _____ times/week<br>5 = High intensity activities that result in sustained heavy breathing and perspiration (running, distance cycling): #_____ times/week |
| Duration | How many minutes you exercise per session? |

## COGNITIVE FUNCTION

| Select only the statements which apply to you. | |
|---|---|
| ☐ I frequently forget appointments. | ☐ Sometimes when I'm looking for something I forget what it is. |
| ☐ I rarely feel energetic. | ☐ My friends and family think I'm more forgetful now. |
| ☐ Small problems upset me more than they once did. | ☐ It's hard for me to concentrate for even an hour. |
| ☐ It takes me longer to learn something than it used to. | ☐ I often forget the point I'm trying to make. |
| ☐ To feel mentally sharp, I depend upon caffeine. | |

## SLEEP

| What time do you wake up? | What time do you go to bed? | Do you feel refreshed waking up? | Do you use sleep aids? |
|---|---|---|---|
| | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| How long does it take you to fall asleep? | | How many times do you wake up at night? | |

## MEN

| Select only the statements which apply to you. | |
|---|---|
| ☐ Fatigue, tiredness, loss of energy | ☐ Anxiety, nervousness |
| ☐ Irritability, anger, bad temper | ☐ Relationship problems with partner |
| ☐ Low libido | ☐ Erectile dysfunction during sex |
| ☐ Decreased morning erections | ☐ Decreased intensity of orgasms |
| ☐ Backache, joint pain, stiffness | ☐ Loss of fitness |
| ☐ Memory loss, decreased ability to concentrate | ☐ Feeling over-stressed |

## WOMEN

Date of last period _____

| Select only the statements which apply to you. | |
|---|---|
| ☐ Menstrual cycle is irregular | ☐ Losing hair on top of head |
| ☐ Menstrual cycle is too short (<27 days), or too long (>31 days) | ☐ Lower belly is swollen |
| ☐ Heavy periods | ☐ Face is too hairy |
| ☐ Periods are continuously painful | ☐ Hot flashes |
| ☐ Menstrual flow is light | ☐ Feel anxious |
| ☐ Menopause | ☐ Breasts are swollen and tender or painful before period |

## HORMONE REPLACEMENT THERAPY QUESTIONNAIRE

| Do you have any experience with hormone replacement therapy? If YES, please explain. |
|---|

| |
|---|
| ☐ Yes ☐ No |
| Are there any treatments you are particularly interested in? If YES, please explain. |
| ☐ Yes ☐ No |
| What are you hoping to gain with hormone replacement therapy? |
| |

## MISCELLANEOUS

| |
|---|
| Please include any additional information we should know. |
| |

| Patient Signature | Print Name | Date |
|---|---|---|
| | | |
| Doctor Signature | Print Name | Date |
| | | |