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)? _____

_____

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

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
_____	_____	_____

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:

_____ _____

_____ _____

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? _____

_____

_____

