INITIAL HISTORY/PRECONSULT FORM (5 pages)

Patient Name (on each page): ______________________ DOB: __________

List, in order of importance, your goals for working with your physician:

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

Which of your physicians would you consider in charge of you care?: ______________________

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when died:						
Reason for death:						
Cancer Type (if had):						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, Including Date Occurred:

1) ______________________ 4) ______________________
2) ______________________ 5) ______________________
3) ______________________ 6) ______________________

Please Note When & Why You Have Had Each of the Following:

X-Rays: ______________________ MRI/Cat Scans: ______________________
Ultrasounds: ______________________ Accidents: ______________________
TB Test: ______________________ HCV: ______________________
HIV: ______________________ Last Dental Visit: ______________________
Last Eye Exam: ______________________ Last Gyn Exam: ______________________

Did you have the following Disease (D), Get Immunized (I), or Neither (N):

Measles	D I N	Chicken Pox	D I N	Mumps	D I N	Rubella	D I N
Tetanus	D I N	Whooping Cough	D I N	Hemophilus (Hib)	D I N	Hepatitis B	D I N
German Measles	D I N	Gardisil	D I N	Any Vaccine Reactions:			

Patient Name: ______________________ DOB: ____________

List Yes (Y), No (N) or Past (P) regarding use of the following:

Antacids: Y N P Steroids: Y N P Smoking: Y N P Packs per day & number of years: ____________

Analgesics: Y N P Laxatives: Y N P Coffee: Y N P Cups per day if Yes/Past: ____________

Soda Pop: Y N P Ounces per day if Yes/Past: ________

Alcohol: Y N P How often & how much if Yes/Past: ____

Any Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P

Recreational Drugs: Y N P Any Drug Addictions: Y N P

Any Drug Treatment: Y N P

List all prescription medicines that you are taking and include dosage if known:

____

____

____

Review of Systems

Present Weight:		Wt. One Month Ago:		Wt. One Year Ago:		Height:	
Max Weight/ When:		Min Weight/When:		Ideal Weight:			

REGARDING THE NEXT LONG SECTION:
Please circle (Y) if you have the problem NOW, (N) if you've NEVER had the problem, (P) if you had the problem in the PAST.

Do you have good energy? Y N P

Are you fatigued now? Y N P

If you have fatigue, when in morning, afternoon, evening is it the worst? ____________

If you have fatigue, can you do what you need to during the day? Y N

SKIN				
Rash:	Y N P		Color Change:	Y N P
Hives:	Y N P		Lump:	Y N P
Psoriasis/Eczema:	Y N P		Itchy:	Y N P
Dry:	Y N P		Warts/Moles:	Y N P
Cancer of the Skin:	Y N P		Perspiration:	Y N P
HEAD				
Headache:	Y N P		Migraine:	Y N P
Dandruff:	Y N P		Head Injury:	Y N P
Oil/Dry Hair:	Y N P		Hair Loss:	Y N P
NOSE				
Frequent Colds:	Y N P		Nosebleeds:	Y N P
Congestion:	Y N P		Post Nasal Drip:	Y N P
Polyps:	Y N P		Seasonal Allergies:	Y N P

Patient Name: ______________________________ DOB: ______________

EYES				
Dry/Watery:	Y N P		Blurry Vision:	Y N P
Double Vision	Y N P		Cataracts:	Y N P
Glaucoma:	Y N P		Styes:	Y N P
Strain:	Y N P		Discharge:	Y N P
Itchy:	Y N P		Dark Under Eyelid:	Y N P
MOUTH/THROAT				
Canker Sores:	Y N P		Cold Sores:	Y N P
Sore Throat:	Y N P		Gum Disease:	Y N P
Dentures:	Y N P		Cavities:	Y N P
Loss of Taste:	Y N P		Hoarseness:	Y N P
		NECK		
Stiffness:	Y N P		Swollen Glands:	Y N P
Restricted Movement:	Y N P		Tension:	Y N P
RESPIRATORY				
Cough:	Y N P		TB:	Y N P
Shortness of Breath w/ Exertion:	Y N P		Bronchitis:	Y N P
Shortness of Breath Sitting:	Y N P		Pneumonia:	Y N P
Shortness of Breath Lying:	Y N P		Asthma:	Y N P
Wheezing:	Y N P		Painful Breathing:	Y N P
CARDIOVASCULAR				
High Blood Pressure:	Y N P		Rheumatic Fever:	Y N P
Low Blood Pressure	Y N P		Murmurs:	Y N P
Arrhythmias:	Y N P		Palpitations:	Y N P
Edema:	Y N P		Chest Pain:	Y N P
URINARY TRACT				
Incontinence:	Y N P		Pain w/ Urination	Y N P
Frequent Infections:	Y N P		Kidney Stones	Y N P
Urgency:	Y N P		Discharge/Blood:	Y N P
GASTROINTESTINAL				
Heartburn:	Y N P		Bowel Movement Freq:	
Indigestion:	Y N P		Recent BM Change:	Y N P
Bloating:	Y N P		Diarrhea/Constipation:	Y N P
Nausea:	Y N P		Hemorrhoids:	Y N P
Vomiting:	Y N P		Gall Bladder Disease:	Y N P
Change in Appetite:	Y N P		Liver Disease:	Y N P
Pancreatitis:	Y N P		Ulcer:	Y N P

Patient Name: ____ DOB: ____________

MALE GENITALIA				
Testicular Pain/Swelling:	Y N P		Sexually Active:	Y N P
Hernia:	Y N P		S.T.D.:	Y N P
Discharge:	Y N P		Prostate Disease/Symptoms:	Y N P
Sexual Orientation	Hetero Homo Bi		Impotence:	Y N P

FEMALE GENITALIA				
Age Period Began:			How Often Period Occurs:	
How Long period lasts:			Heavy Menstrual Bleeding:	Y N P
Menstrual Cramping:	Y N P		Breast Tenderness:	Y N P
PMS:	Y N P		Food Cravings:	Y N P
Times Pregnant:			How Many Births:	
Miscarriages:			Abortions:	
Last Pap Smear:			Abnormal Pap Diagnosis:	
Any Abnormal Paps:	Y N P		When Pap Was abnormal:	
Menopausal Since What Age:			Use of Hormones:	Y N P
Any Hormones Used:			Decreased Libido:	Y N P
Dry Vagina:	Y N P		Sexually Active:	Y N P
Pain w/ Intercourse:	Y N P		Vaginitis:	Y N P
S.T.D.:	Y N P		Mammography:	Y N P
Sexual Orientation (circle)	Hetero Homo Bi		If Yes, what were results:	

Please list any birth control used and ages used: ____

MUSCULOSKELETAL				
Weakness:	Y N P		Arthritis:	Y N P
Stiffness:	Y N P		Leg Cramps:	Y N P
Tremors:	Y N P		Pain:	Y N P

NERVOUS				
Paralysis:	Y N P		Sciatica:	Y N P
Tingling/Numbness:	Y N P		Carpal Tunnel Syndrome:	Y N P
Seizures:	Y N P		Fainting:	Y N P

EMOTIONAL				
Depression:	Y N P		Anger/Irritability:	Y N P
Suicidal:	Y N P		High-Strung/Tense:	Y N P
Anxiety:	Y N P		Fear/Panic	Y N P
Eating Disorder:	Y N P		Psych Hospitalization:	Y N P

Patient Name: ______________________________ DOB: ____________

Exercise

How often do you exercise? ______________ What type of exercise? ______________________

For how long? ____________________ Hobbies: ______________________________

____

Sleep

How long per night? ______________ If you wake up frequently, what is the reason? ______________

Nightmares: Y N P | Wake Refreshed: Y N P | Must Nap During the Day: Y N P

Sleep Walk: Y N P | Grind Teeth: Y N P | Snore: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? ______________________________

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? ______________

____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing?

____

Are you particularly sensitive to perfumes, gasoline or other vapors? ______________________

Do you use pesticides, herbicides or other chemicals around your home? ______________________

____

Social Life

****** We understand that the following information is quite personal. Providing it is optional, but may be helpful to your proper care and comfort*******

Enjoy Job: Y N P Hours Worked per Week: ______ Highest Level of Education: ______________________

Active Spiritual Practice: Y N P Quality of Significant Relationship: ______________________

History of Sexual, Mental/Emotional, Physical Abuse: Y N P If So, At What Age and By Whom: ______________

What is your greatest health concern?: ______________________________

How does it limit you the most?: ______________________________

How committed are you towards making valuable changes?: Little Moderately Very

Typical Day's Diet

Breakfast: ______________________________

Lunch**:** ______________________________

Dinner: ______________________________

Snacks: ______________________________

Patient Name: ______________________________ DOB: ______________

LIST OF DOCUMENTS REQUESTED FOR INITIAL OFFICE VISIT

1. All pathology reports
2. Up to five of your most recent lab results (if available)
3. Up to three of your most recent imaging studies (such as: CT, bone scan, P.E.T., X rays) if available
4. Surgical/operative reports
5. A listing of all supplements and medications you are currently taking with dosages (below):

Supplement/Medicine	Dosage	Reason for Using
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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