Coastal Medical Clinic P.C.

Personal Health History

Demographic Information

Name_____SS #_____ Birth Date_____

Age_____Sex_____ Marital Status_____Home#_____Work#_____

Home Address_____City_____State_____Zip_____

Cell Phone_____ Email Address_____

Employer_____Job Title_____

Emergency Contact_____Number_____Referral _____

Personal Physician _____Office _____

Address_____

Preferred Pharmacy Name_____Number_____

HISTORY
This section is for the purpose of learning more about your health history. Please read and answer all of the following questions to the best of your knowledge.

Reason for Consultation

What health concern and symptoms brings you to the clinic?_____
_____
_____
_____
_____
_____
_____
_____
_____
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_____
_____

Patient Name _____Birth Date_____

What would you most like to achieve with this health consultation?_____
_____
_____
_____
_____
_____
_____
_____

Are you currently under the care of a physician or health professional for a medical/health condition? Yes____No____ If yes, please list condition(s):_____
_____
_____
_____

PAST MEDICAL HISTORY

Please check any medical conditions or health problems that you currently have or have had in the past? List any additional health problems not listed.

Headaches (migraines, other)	Yes	No	Heart Disease	Yes	No
Seizures Disorder	Yes	No	Chest Pain	Yes	No
Recurrent sinus infections	Yes	No	Irregular Heart beat	Yes	No
Seasonal allergies	Yes	No	High Blood Pressure	Yes	No
Psychiatric/Emotional Illness	Yes	No	Blood Clotting prob	Yes	No
Depression	Yes	No	Bleeding disorders	Yes	No
Anxiety/excess stress	Yes	No	Stroke/vascular dis	Yes	No
Asthma	Yes	No	Constipation/diarrhea	Yes	No
Chronic Bronchitis	Yes	No	Hepatitis/Liver dis	Yes	No
Lung/breathing problems	Yes	No	Kidney disease	Yes	No
Chronic Indigestion	Yes	No	Menstrual disorders	Yes	No
Stomach Ulcer	Yes	No	Reproductive probl	Yes	No
Intestinal disease	Yes	No	Prostate problems	Yes	No
Skin problems/dermatitis	Yes	No	Sexual/Libido probl	Yes	No
Back Pain/Scoliosis	Yes	No	Tendonitis	Yes	No
Herniated Disc	Yes	No	Chronic pain problem	Yes	No
Neck pain	Yes	No	Shoulder problems	Yes	No
Chronic Muscle/joint pain	Yes	No	Osteoarthritis	Yes	No
Carpal Tunnel Syndrome	Yes	No	Rheumatoid Arthritis	Yes	No
Fibromyalgia	Yes	No	Artificial joint/implant	Yes	No
Diabetes	Yes	No	Cancer	Yes	No
Thyroid disease	Yes	No	Psoriasis/eczema	Yes	No
Osteoporosis/Osteopenia	Yes	No			

Patient Name _____Birth Date_____

List any surgeries/ operations you have had and when: _____
_____
_____
_____

List any medications you are currently taking (or have taken in the recent past)

Medication Name Date Started Date Stopped Dosage
_____
_____
_____
_____
_____
_____
_____

Nutritional supplements, vitamins, herbs, homeopathic remedies taken: _____
_____
_____
_____
_____
_____
_____
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_____

Medication Allergies: _____
_____
_____

Environmental/Food Allergies: _____
_____
_____

Preventative Tests: Month/Year of last test Test Results (if known)

Cholesterol _____

Bone Density _____

Colonoscopy _____

Exercise Stress Test _____

Patient Name: _____Birth Date_____

Family History (write the relationship of the relative(s) with the disease on adjacent line)

Heart Disease yes no _____

High Blood Pressure yes no _____

Diabetes yes no _____

Arthritis yes no _____

Skin disorders yes no _____

Breast Cancer yes no _____

Uterine/Ovarian Cancer yes no _____

Prostate Cancer yes no _____

Colon Cancer yes no _____

Other Cancer yes no _____

List any other disease/condition in the family and relationship: _____
_____
_____

WOMEN

Are you pregnant? Yes No First day of last menstrual cycle: _____
Date of last pap/pelvic/breast exam: _____ Results: normal abnormal
Date of last mammogram: _____Results: normal abnormal
Do you perform monthly self breast exams Yes No

Are you currently taking or have you in the past taken hormones or oral contraceptives
Yes No
If yes, please list all hormones and oral contraceptives you have taken and when: _____
_____
_____
_____
_____
_____
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_____

Patient Name _____Birth Date_____

Have you ever had any problems or concerns taking hormone replacement therapy?
Yes No
If yes, please list problem:_____
_____
_____
_____

How many pregnancies have you had? _____ How many children? _____
Have you had a hysterectomy? Yes No If yes, were your ovaries removed Yes No
Have you had any menstrual irregularities? Yes No If yes explain _____
_____
_____
_____
Has your abdominal girth and weight been increasing? Yes No

MEN
Date of last prostate exam_____
Are you concerned with loss of muscle mass, tone, or strength? Yes No
Have you had problems with urination? Yes No
(Decreased stream, frequent night urination)
Do you perform periodic testicular self examinations? Yes No
Has your abdominal girth and weight been increasing? Yes No

SOCIAL HISTORY AND PERSONAL HEALTH HABITS
General (Circle all that apply)

My health is excellent good fair poor
My physical fitness is excellent good fair poor
I am under a lot of stress. I am fatigued all the time. I am having difficulty dealing with stress. I practice meditation or other relaxation techniques.
I am often sad and blue.

Dietary Habits
No special diet habits Avoid red meats Minimize fat Minimize carbs
Vegetarian Emphasize fruits/grains/vegetables I try to eat a healthy diet I do not eat dairy/cheese I commonly eat fast food restaurants
I commonly consume: Coffee Regular soft drinks Diet soda
Candy/chocolate Chips/crackers
Exercise Habits
No special exercise habits I routinely exercise __hr(s) ____x/week
Aerobic exercise (jog/walk/treadmill) Lift weights Swim
Stretch/Yoga/TaiChi/ChiGong
Other_____

Patient Name _____Birth Date_____

Tobacco Use
I never smoked cigarettes or chewed tobacco
I now smoke_____ packs/day. I have smoked for _____years.
I quit smoking in _____ (mo/yr) I smoked ____ packs/day for _____years
I smoke cigars/pipe

Alcohol use
I never drink alcohol I drink occasionally or socially I drink regularly
1-2 drinks/day more than 2drinks/day more than 4 drinks/day

Hobbies/Sports/Recreation
List routine hobbies/sports/recreational activities: _____
_____
_____

_____
Patient Signature Date

Practitioner comments on above: _____
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