Adult Health Summary

|  |  |  |
| --- | --- | --- |
| Name: | Date: | Date of birth |
| Home ph: | May I call you at this number?  Is it OK to leave a message? | Age |
|  |
| Work ph: | May I call you at this #?  Is it OK to leave a message? |  |
|  |
| Cell ph: | May I call you at this number?  Is it OK to leave a message? |  |
|  |
| E-mail: | May I contact you via e-mail? |  |
| Address | | |
| City, State, Zip | | |
| Who may we thank for referring to our office? | | |

**Past Medical History**

Put an **“X”** by things you have had in the past. ***Write in the year*** the condition started.

Put a **“C”** for things you are currently experiencing.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | AIDS |  | Congestive Heart Failure |  | HIV positive |  | Rheumatoid arthritis |
|  | Alcoholism |  | Depression |  | Joint replacement |  | Scarlet fever |
|  | Anemia |  | Diabetes |  | Kidney Disease |  | Sexually transmitted disease |
|  | Anorexia |  | Drug Dependent |  | Liver Disease |  | Stroke |
|  | Anxiety |  | Emphysema |  | Measles |  | Suicide attempt |
|  | Appendicitis |  | Epilepsy |  | Migraines |  | Suicide thoughts |
|  | Arthritis |  | Glaucoma |  | Miscarriage |  | Thyroid problems |
|  | Asthma |  | Gonorrhea |  | Mononucleosis |  | Tonsillitis |
|  | Bleeding Disorders |  | Gout |  | Multiple Sclerosis |  | Tuberculosis |
|  | Blood in urine |  | High blood pressure |  | Mumps |  | Ulcers |
|  | Breast Lump |  | Heart murmur |  | Panic Attacks |  | Unconsciousness |
|  | Bronchitis |  | Hepatitis |  | Pacemaker |  | Vaginal Infections |
|  | Bulemia |  | Hernia |  | Pneumonia |  | Other: |
|  | Cancer |  | Herpes |  | Polio |  |  |
|  | Cataracts |  | Hiatal Hernia |  | Psychiatric care |  |  |
|  | Coma |  | High Cholesterol |  | Rheumatic Fever |  |  |

**Past Surgeries/Procedures** (Include Dental—ex. Root canal, teeth pulled)

|  |  |
| --- | --- |
| Surgery | Date |
|  |  |
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**Trauma History—**Check (**X**) any box which apply and explain circumstances and when occurred.

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| --- | --- |
|  | Motor vehicle accident—if so, when |
|  | Fall—if so, when, how high and injuries? |
|  | Other trauma/injuries: |

**Social History—**Check (**X**) any box that applies

|  |  |
| --- | --- |
|  | Alcohol— # drinks/day or week |
|  | Cigarette-- # packs/day or week |
|  | Recreational drug use |
|  | Occupation: |
|  | Marital Status: |
|  | Religious/spiritual preference: |
|  |  |

**Exercise—**Check (**X**) any box that applies

|  |  |
| --- | --- |
|  | What do you do for exercise? |
|  | How often do you exercise? # days/week |
|  | How long do you exercise? Minutes/day |

**Medications/Herbals/Supplements—**dose and frequency, when started

|  |  |
| --- | --- |
| Medication/Herbal/Supplements | **Start** |
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**Allergies**—List any medications, foods, environmental allergies and the reaction.

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**Family History—**If any blood relative has suffered from any of the following, please check (**X**) and ***indicate the relative***

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| --- | --- | --- | --- | --- | --- |
|  | Allergies |  | Cancer---what type |  | Heart disease |
|  | Asthma |  | Diabetes |  | High blood pressure |
|  | Anemia |  | Epilepsy/Seizure |  | Kidney/bladder problems |
|  | Arthritis |  | Glaucoma |  | Mental Illness |
|  | Alcoholism |  | Gout |  | Stroke |
|  | Blood Clotting Problems |  | Headaches/migraines |  | Other: |

**Consultants--**Please list other practitioners you see—other physicians, chiropractors, acupuncturist etc and phone #

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**Review of Systems:**

Put an **“X”** by things you have had in the past. Write in the year condition started.

Put a **“C”** for things you are currently experiencing.

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **General** |  | **Cardiac/vascular** |  | **GU** |  | **Skin/breast** |
|  | Fever |  | Chest pain |  | Bladder control |  | Eczema |
|  | Chills |  | Chest pressure |  | Blood in urine |  | Hives |
|  | Night Sweats |  | Fainting |  | Decrease force or urine |  | Itching |
|  | Weight Loss |  | Heart murmur |  | Painful intercourse |  | Rashes |
|  | Fatigue |  | High blood pressure |  | Painful urination |  | Yellow skin/eyes |
|  | Loss of energy |  | Irregular heart beat |  | Pelvic pain |  | Breast lumps |
|  | Loss of sleep |  | Leg pain when walk |  | Sexual dysfunction |  | Nipple discharge |
|  | **Eye** |  | Lightheaded |  | Urinary hesitancy |  | **Allergies/Immun** |
|  | Blurred vision |  | Low blood pressure |  | bedwetting |  | Seasonal allergies |
|  | Double vision |  | Pass out |  | **Neurology** |  | Other allergies |
|  | Crossed-lazy eye(s) |  | Palpitations |  | Cold or numb hands/feet |  | **Diet--# servings/day** |
|  | Eye pain |  | Phlebitis |  | Convulsions (seizures) |  | Water |
|  | Loss of vision |  | Poor circulation |  | Frequent headaches |  | Coffee |
|  | Visual Flashes |  | Shortness of breath |  | Muscle weakness |  | Tea |
|  | Visual Halos |  | At rest |  | Numbness/tingling |  | Soda |
|  | Had laser surgeries |  | With exertion |  | Tremors |  | Meats |
|  | Wear glasses or contacts |  | Lying flat |  | Unsteady walking |  | Chicken |
|  | **Ear, Nose, Throat** |  | Swollen ankles |  | Vertigo/spinning |  | Fish |
|  | Decreased hearing |  | Varicose Veins |  | **Psychosocial** |  | Breads/cereal |
|  | Earache |  | **Pulmonary** |  | Anxiety |  | Dairy products |
|  | Ear discharge |  | Cough |  | Depression |  | Fruits |
|  | Ear fullness |  | Wheezing |  | Nervousness |  | Fruit juice |
|  | Ear infections |  | **Gastrointestinal** |  | **Behavior** |  | Vegetables |
|  | Ear ringing-buzzing |  | Abdominal pain |  | Lack of emotional control |  | **Female only** |
|  | Hoarseness (prolonged) |  | Black stools |  | Irritable |  | # of pregnancies |
|  | Jaw Clicking |  | Bloating |  | Hyperactive |  | # of live births |
|  | Jaw locking |  | Blood in stools |  | Easily distracted |  | # of miscarriages/abortions |
|  | Nosebleeds |  | Constipation |  | Poor attention span |  | # vaginal deliveries |
|  | Post nasal drip |  | Diarrhea |  | Impulsive |  | # c-sections |
|  | Sinus problems |  | Heartburn |  | **Endocrine** |  | Method of birth control |
|  | Sore throat (frequent) |  | Hemorrhoids |  | Excessive weight gain |  | Periods are: |
|  | Swallowing difficulty |  | Nausea |  | Excessive weight loss |  | Regular |
|  |  |  | Vomiting |  | Heat intolerance |  | Irregular |
|  |  |  | **Heme/lymph** |  | Cold intolerance |  | Painful |
|  |  |  | Easy bruising |  | Hair falling out |  | Heavy |
|  |  |  | Bleeding gums |  | Excessive thirst |  | Scant |
|  |  |  | Lymph nodes |  |  |  |  |
|  |  |  |  |  |  |  |  |
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**History of Present Illness**:

Please describe your problem(s) in as much detail as possible. If you have more than one problem, number each problem and answer each question separately for each issue. You may use a second sheet of paper if necessary.

**What** all of symptoms are--

**When** symptoms began--

What makes it **better—**

What makes is **worse—**

**How often** do symptoms occur?

**How long** do symptoms last when you get them--

**Treatments** tried and their effect on your problem --

All health care providers seen for this problem, the **diagnosis** they gave you, tests or x-rays done, and treatment given—

Please answer “yes” or “no” to the following questions:

**Do you have a juicer?**

**Do you have a blender, vitamix or blendtec? (circle one)**

**Do you have a food dehydrator?**

**Do you have a food processor?**

**List what you typically have for breakfast, lunch, dinner and snacks.** Include times when foods are eaten.

Be specific—if you have a sandwich, write down type of bread, meat, etc. If have cereal, what kind. What kind of milk do you drink (skim, whole, raw, pasteurized, almond milk etc). What do you put in your salads? What do you put on your veggies (ex. Butter, oil)? If you eat pizza, what is on the pizza?