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**

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

	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**

Allergies—List any medications, foods, environmental allergies and the reaction.

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

	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 #

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.

	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				

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?