Pleasant Hill Wellness Center

A Medical Corporation

Your answers on this form will help your provider understand your medical concerns and conditions better.

Patient Name: ______________________________ DOB: ______________

Age: ________ How would you rate your general health? ___ Excellent ___ Good ___ Fair ___ Poor

Present Health Concerns: ____

____

Medications: List prescription and non-prescription meds, Vitamins, Herbs, Birth Control, etc.

Medication:	Dosage:	How many times per day?:
____________________	_____________	____________________
____________________	_____________	____________________
____________________	_____________	____________________
____________________	_____________	____________________
____________________	_____________	____________________
____________________	_____________	____________________
____________________	_____________	____________________

Please list any allergies to medications: ____

When was your last Tetanus shot? ____________

Health Maintenance:

Last Mammogram: ________ (Normal/Abnormal) Circle One   Last Pap Smear: ________ (Normal/Abnormal) Circle One

Last PSA (Prostate Cancer Screen): ________ (Normal/Abnormal) Circle One

Personal Medical History: Please indicate whether you have had any of the following medical problems, including dates:

___ Heart Disease ________
___ Heart Attack ________
___ High Blood Pressure ________
___ Diabetes ________
___ High Cholesterol ________
___ Thyroid Problem ________

___ Bleeding/Clotting ________
___ Blood Transfusion ________
___ Cancer ________
___ Stroke ________
___ Depression ________
___ Anxiety/Panic Attacks ________
___ Alcoholism ________

Other: ____________________
____
____
____

Surgical History: Please list all prior surgeries, including dates:

Surgery	Date
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

The Following is a list of medical conditions that may run in families. Please indicate on the chart below whether any of your family members has any of the following.

Medical Condition:	Relation:	Medical Condition:	Relation:
___ Alcoholism	________	___ High Blood Pressure	________
___ Anemia	________	___ High Cholesterol	________
___ Anesthesia Problems	________	___ Immunosuppressive Disorder	________
___ Arthritis	________	___ Kidney Diseases	________
___ Asthma	________	___ Mental Retardation	________
___ Birth Defects	________	___ Osteoporosis	________
___ Bleeding Disorder	________	___ Seizure Disorder	________
___ Cancer:	________	___ Smoking	________
Type: ________	________	___ Stroke	________
___ Depression	________	___ Substance Abuse	________
___ Diabetes Type II	________	___ Thyroid Disorder	________
___ Eczema	________	___ Tuberculosis	________
___ Hay Fever/Allergies	________	___ Other: ________	
___ Hearing Problems	________	________	
___ Heart Disease (CAD)	________	________	

Social History: Please mark all that apply:

Cigarettes: ___ Never ___ Quit: Date ________ ___ Current Smoker: Packs per day ______ # Yrs ______

Other Tobacco: ___ Pipe ___ Cigar ___ Snuff ___ Chew

Are you interested in quitting? ___ Yes ___ No

Do you drink alcohol? ___ No ___ Yes: # drinks/week ________

Is alcohol use a concern for you or others? ___ Yes ___ No

Do you use recreational drugs? ___ No ___ Yes: ________ Have you used needles? ___ Yes ___ No

Have you ever had any sexually transmitted diseases? ___ No ___ Yes: ________________

Are you interested in being screened for Sexually transmitted diseases? ___ Yes ___ No

Do you exercise regularly? ___ No ___ Yes What kind of exercise? ________________________

How long? ________ How often? ________ If you don't exercise, why? ________________

Review of Symptoms: Please check all current problems you have on the list below:

Constitutional

___ Fever/Chills/Sweats
___ Unexplained weight loss/Gain
___ Change in energy/Weakness
___ Excessive thirst/Urination

Eyes

___ Change in vision

Ears/Nose/Throat/Mouth

___ Difficult hearing/ringing in ears
___ Problems w/Teeth/Gums
___ Hay Fever/Allergies

Cardiovascular

___ Chest pain/discomfort
___ Palpitations
___ Fainting

Other: ________________

____

Respiratory

___ Cough/Wheeze
___ Difficulty Breathing

Gastrointestinal

___ Abdominal pain
___ Blood in bowel movement
___ Nausea/Vomiting/Diarrhea

Genitourinary

___ Nighttime urination
___ Leaking urine
___ Unusual vaginal bleeding
___ Discharge: penis or vagina

Musculoskeletal

___ Muscle/Joint pain

Skin

___ Rash
___ Mole change

Neurological

___ Headaches
___ Dizziness/Lightheadedness
___ Numbness
___ Memory Loss
___ Loss of coordination

Psychiatric

___ Anxiety/Stress
___ Depression
___ Problems w/Sleep

Blood/Lymphatic

___ Unexplained lumps
___ Easy bruising/Bleeding

Chest (breast)

___ Breast lump
___ Nipple Discharge