TRANSVALLEY FAMILY HEALTH, PLLC

Name _____ Date of birth ____/____/____

Current Problem

What medical problem do you want to have evaluated and treated? Briefly describe the history of this problem (onset, severity, intensity, modifying factors, etc .)

_____

_____

_____

_____

_____

_____

_____

What other treatments have you tried? Have the treatments helped?

_____

_____

_____

Past Medical History

Circle & list any past/chronic medical problem: Asthma, COPD, hypothyroidism, diabetes, high blood pressure, heart disease/heart attack, atrial fibrillation, stroke/CVA or mini stroke/TIA, anxiety, depression, ear infections, sinusitis, bladder infection, Reflux/GERD, colitis/diverticulitis, peptic ulcer, constipation, hemorrhoids, irritable bowel syndrome, anemia, varicose veins, leg swelling, migraines, eczema, psoriasis, acne, liver disease, kidney stones, kidney disease, urinary tract infections, infertility or miscarriages, cancer, Lyme infection, fibromyalgia, arthritis _____

_____

_____

_____

Medications Current medicines/supplements (name and dose):

_____

_____

_____

_____

Reviewed by _____ date: _____

Allergies to medicines (also, what was your reaction): _____

_____

_____

Social history

*R*egular exercise? Y / N Healthy diet? Y / N Caffeine: _____ cups/day

Tobacco use? Y / N Alcohol: ____ drink/day or occasion; ____ drink/week

Other drug use? Y / N _what drug(s) and usage _____

Occupation: _____ Company: _____

Marital status: [ ] Single [ ]Married [ ]Divorced [ ]Widowed

Family medical history

Father (alive/deceased): _____

Mother (alive/deceased): _____

Brothers/Sisters: _____

_____

_____

Do you have a short leg? Y / N / unknown If yes, which one? R / L

Do you wear a heel lift? Y / N

Have you ever had any teeth pulled? Y / N If yes, where in your mouth? _____

Your birth history (normal vaginal or c-section, difficulties, etc):_____

_____

Past hospitalizations/surgeries (with approximate dates):

_____

_____

_____

_____

History of abusive trauma (circle)*: None Mental Physical Sexual* _____

Other trauma history (car accidents, falls, fractures, etc and when did it occur):

_____

_____

_____

_____

Reviewed by _____ date: _____

Please circle any other symptoms you are having

General: fatigue, sweats, fever, chills, excessive weight gain or loss, cold hands or feet

HEENT: allergies, headache, vision problem, light or noise sensitivity, hearing problem, ringing in the ear, dizziness, runny or stuffy nose, sinus pressure/pain, sore throat, painful swallowing

CV: chest pain or tightness, leg swelling, irregular heart beat, difficult breathing laying flat, dizziness with change in position

Pulm: coughing, cough up blood or sputum, wheezing, trouble breathing at rest or with exertion, excessive snoring, stop breathing at night

GI: nausea, vomiting, heartburn, abdominal bloating, abdominal pain, constipation, diarrhea, blood in stool, painful hemorrhoids, loss of appetite

GU: kidney/bladder problems, pain/burning when urinate, frequent urination, blood or pus in urine, incontinence, urgency, difficulty urinating.

Female: pregnancy, pelvic pain, irregular /heavy/abnormal periods

Male: erectile dysfunction, night time urination

Skin: Rash, ulcers/sore, itchiness, acne

MS: muscle spasm/cramps/pain, muscle weakness, joint pain or swelling or redness

Endo: excessive thirst or urination, heat or cold intolerance

Heme/lymp: excessive bruising or bleeding, swollen glands

Neuro: headache/migraines, numbness/tingling, lightheaded, loss of sensation, tremor, gait problem, falls, confusion, weakness - generalized or localized in _____, memory problem

Psych: depression, suicidal/homicidal thoughts, anxiety, worrying, labile mood, irritable, trouble thinking clearly, poor concentration, insomnia - hard to fall asleep or stay asleep.

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How did you hear about our office? _____

Reviewed by _____ date: _____