TRANSVALLEY FAMILY HEALTH, PLLC

Name _____ Gender: _____ 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 .)

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Describe your PAIN: Rating 0-10: _____ Quality: Dull Achy Sharp /stabbing Pressure

Onset & Timing: _____

Frequency & duration: _____

Worse with: Heat Cold Humidity Movement/Walking/Standing/Sitting/Lying/Being still

_____

Better with: Heat Cold Humidity Movement/Walking/Standing/Sitting/Lying/Being still

_____

What treatments have you tried? Have the treatments helped?

_____

_____

_____

Past Medical History

Circle & list all of your childhood/adulthood illnesses. For recurrent problem, indicate how often. For example: ear infections - few times/year until age 6; sinusitis - R every fall since 35.

COPD, hypothyroidism, diabetes, high blood pressure, heart disease, atrial fibrillation, asthma, stroke or mini stroke, psoriasis, acne, varicose veins, leg swelling, infertility or miscarriages, Reflux/GERD, colitis/diverticulitis, peptic ulcer, hemorrhoids, irritable bowel syndrome with constipation +/- diarrhea, anemia, migraines, eczema, liver/kidney disease, kidney stones, scoliosis, fibromyalgia, arthritis:_____, cancer - type:_____

Reviewed by _____ date: _____

Lyme infection:_____ Mold infection _____

Other Infections: _____

_____

_____

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_____

Medications Current medicines/supplements (name and dose):

_____

_____

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Allergies to medicines (what was the reaction): _____

_____

Social history

Marital status: Single Married Divorced Widowed Occupation: _____

Do you feel safe at home & at work? Y / N Who lives with you: _____

State/Cities you've lived in:_____

Pets you had/currently have _____

Tobacco use? Current / Former / Never Alcohol: ____ drinks/occasion; ____ drinks/week

Illicit drug use? Y / Never / Not currently. _____ Caffeine: _____ cups/day

Type of diet: _____ Servings of fruits _____ & vegetables _____ per day

Sugar/sweets/junk or process food: Rare Sometimes Often Daily

Taste craving: Salty Sweet Sour Spicy Fatty Cold / Hot food/drinks

Taste avoidance: Salty Sweet Sour Spicy Fatty Cold / Hot Onion / Garlic / Dairy

Exercise: What kind & how often: _____

Stress level: Low Moderate High @Work @Home Ways to mange stress: _____

_____

Reviewed by _____ date: _____

Family medical history - list all illnesses
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 trauma (circle & describe - ongoing?)*: None Mental/Emotional / Sexual abuse Fall / Fractures /Motor Vehicle Accidents / Injuries*

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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, lost or altered sense of taste or smell

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

Pulm: coughing, sputum - clear or bloody, wheezing, trouble breathing at rest or with exertion, air hunger, excessive snoring, stop breathing at night

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

Urinary/GYN: kidney/bladder problems, pain/burning when urinate, frequent urination,

Reviewed by _____ date: _____

blood or pus in urine, incontinence, urgency, difficulty urinating.

Female: pregnancy, pelvic pain, irregular /heavy/abnormal periods, PMS, hot flashes

Male: erectile dysfunction, night time urination, weak urine flow

Skin: Rash, ulcers/sore, itchiness, acne, unusual stretch marks

MS: muscle spasm/cramps/pain, muscle weakness, pain on bottom of feet, 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 - short / long term, brain fog, trouble with word finding

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: _____