Personal Health History Summary
A New Image Weight Loss Clinic, Inc.

Date: _____ Drivers License #:_____ State:_____

Name: _____ DOB:_____ Age; _____ Sex:_____

Street Address: _____ Mailing Address_____

City/St/Zip: _____

Telephone: (Home) _____ (Work) _____ Cell:_____

Employed by: _____ E-mail Address_____

Marital Status: _____ Hobbies: _____

Referred by: _____

Name of other physician who treated you: _____

Date of last complete physical exam: _____

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Current Medications:

1._____

2._____

3._____

Medication Allergies:

1._____

2._____

3._____

Have you ever received a blood transfusion? (Yes /no)_____ If yes when? (Date)_____

Have you ever donated blood? (Yes /no)_____If yes, date of most recent donation: _____

****

Previous Illness/Date:

1._____

2._____

3._____

4._____

5._____

Previous Surgeries/Date:

1._____

2._____

3._____

4._____

5._____

Illnesses:

[ ] Diabetes
[ ] Thyroid Disease
[ ] High Blood Pressure
[ ] Heart Attack
[ ] Heart Murmur
[ ] Rheumatic Fever
[ ] High Cholesterol
[ ] Lung Disease
[ ] Emphysema
[ ] Arthritis
[ ] Lupus
[ ] Depression

[ ] Pneumonia
[ ] Tuberculosis TB
[ ] Bladder Infection
[ ] Kidney Infection
[ ] Kidney Disease
[ ] Kidney Stones
[ ] Asthma
[ ] Bronchitis
[ ] Anemia
[ ] Venereal Disease
[ ] Bone Fracture
[ ] Suicide Attempt

[ ] Stomach/Duodenal ulcers
[ ] Colitis/ bowl disease
[ ] Liver disease/jaundice/hepatitis
[ ] Gallbladder stones/disease
[ ] Easy bleeding
[ ] Blood clots in legs
[ ] Cancer/Tumor
[ ] Eye Disease
[ ] Stroke
[ ] Muscular problems
[ ] Paralysis
[ ] Heart Rhythm Problems

[ ] Glaucoma
[ ] Cataracts
[ ] Prostate Problems
[ ] Alcoholism
[ ] Nervous Breakdown
[ ] Ear Disease
[ ] Sinus Problems
[ ] Skin Problems/Dis.
[ ] Chronic Headache
[ ] Seizures/Epilepsy
[ ] Urinary Problems
[ ] Drug Abuse
[ ] Other

Occupational Exposures- list Toxic or chemical exposures such as coal mining, sand blasting, asbestos, etc.

_____

Habits:

[ ] Smoke cigarettes Y / N packs per day_____ for how many years_____
[ ] smokeless tobacco (chewing tobacco, snuff) Y / N
[ ] Alcohol Y / N drinks per day_____ per week_____

Do you wear your seatbelt while driving or traveling in a vehicle? Y/N

Do you sleep adequately? Y / N explain_____

Do you exercise regularly? Y / N explain_____

Are you under excessive stress? Y / N explain_____

Women's Health:

# of pregnancies_____

# of children born _____

Last menstrual period (date) _____

Age of menopause_____

Date of last pelvic exam_____

Date of last mammogram (breast x-ray) _____

Do you examine your breast regularly? Y / N

Have you ever had a lump in your breast? Y / N

Family History:

Do any diseases tend to run in your family? Y / N If yes please explain: _____

Father: Age_____

Deceased Y/N if yes cause of death_____ Major illnesses: _____

Mother: Age_____

Deceased Y/N if yes cause of death_____ Major illnesses: _____

Brothers:
Age _____Deceased Y/N if yes cause of death_____

Major illnesses: _____

Age _____Deceased Y/N if yes cause of death_____

Major illnesses: _____

Sisters:
Age _____Deceased Y/N if yes cause of death_____

Major illnesses: _____

Age _____Deceased Y/N if yes cause of death_____

Major illnesses: _____

Children:
Age _____Deceased Y/N if yes cause of death_____

Major illnesses: _____