EMERALD WATERS MEDICAL CLINIC
PERSONAL HEALTH HISTORY

Name of Last Primary Care Provider ____________________________Phone #________________Fax#______________

Name, Address, and Phone number(s) of any other Specialist that are involved in your care:

____

____

Surgeries/Hospitalizations

Year	Reason	Hospital

List any other medical problems that other doctors have diagnosed: ____

Have you ever had a blood transfusion? _______yes __________no; If so when: Month_________Year___________

Preventative Health Vaccines up to date?_____Yes_______no; or do you need more information? _____yes______no

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers:

Drug Name	Strength	Frequency

List any allergies to drugs, medications and/or foods:

Drug/Medication/Food	Reaction	

FAMILY HEALTH HISTORY

For Deceased relatives mark a letter "D" and their age at death, specify cause of death if known.

	Age	Significant Health Problems		Age	Significant Health Problems
Father			Children		
Mother					
Siblings(s)					
			P GMother		
			P GFather		
			M GMother		
			M GFather		

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HEALTH HABITS AND PERSONAL SAFETY

All questions contained in this questionnaire are optional and will be kept strictly confidential.

Exercise:

Describe exercise activities: the frequency, intensity, time and type of activity. Ex(2x wkly beginner 1 hr yoga class)

Activities:

Describe your interests, hobbies, spiritual practices, things you do to relax.

Diet:

Are you dieting? ___________ yes ______________no

If yes, are you on a physician prescribed medical diet? _______yes _______no

# of meals you eat in an average day_______________

What have you eaten in the last 24 hours:
If the above dietary recall is atypical for you, describe a typical day here.
List your favorite healthy foods:

Caffeine: ______None _______Coffee ______Tea ______Soda

Number of cups/can per day? ______________________

Alcohol: Do you drink alcohol? ____ yes ____no

If yes, what kind? ____Wine ______ Beer ______Liquor

How many drinks per week____________

Are you concerned about the amount you drink? ______yes ______no

Have you considered stopping? _____yes ______no

Have you ever experienced blackouts? ______yes ______no

Are you prone to “binge” drinking? ______yes ______ no

Do you drive after drinking? _____yes ______no

Tobacco: Do you use tobacco? ______yes ______ no # of years of use:____________ or year you quit___________

Cigarettes – pks/day: ________Chew -#/day:________Pipe-#/day ____________Cigars - #/day_______Vapor-#/day_____

Drugs: Do you currently use recreational or street drugs? ______yes ________no

Have you ever given yourself street drugs with a needle? ________yes _________no

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Sex: Are you sexually active? ______ yes _______no Any discomfort with intercourse? _________yes ___________no
If yes, are you trying for a pregnancy? ________yes ________no
If not trying to conceive; Please list contraceptive or barrier method that you are currently using:

Personal Safety:	Yes	No
Do you live alone?		
Do you have traction stickers or bathtub mat?		
Do you have a fire extinguisher?		
Do you have frequent falls?		
Do you have vision or hearing loss?		
Do you have an Advance Directive or Living Will?		
Do you wear a seatbelt?		
Do you have any tattoos or piercing?		

WOMEN ONLY

Age of onset of menstruation: ____________________Date of last menstruation:__________________
Days between Periods:______________ Heavy periods, irregularity, spotting, pain or discharge: _____yes _______no
Number of pregnancies:___________Numbers of live births:__________Number of Pregnancy Loss_________________
Month/Year of Cesarean Sections:_____/_________ Date of Hysterectomy__________/Ovary removed: Rt___/Lt_____
Date of last PAP: ____/______/_____Date of your Mammogram:____/_____/______Bone Density____/_______/_____
Date of Last Colonscope_____/______/_________
Are you taking Hormone Therapy?___yes_____no; If so please give name(s):_________________________________

	Yes	No
Are you pregnant or breastfeeding?		
Have you had a D&C? If so why____		
Any urinary tract, bladder, or kidney infections within the last year?		
Any blood in your urine?		
Any hot flashes, sweating at night or mood swings?		
Do you have menstrual tension, pain, bloating, or other symptoms at/ or around the time of you period?		
Experienced any recent breast tenderness, lumps, or nipple discharge?		

MEN ONLY

Last Male Health Exam_________/Last PSA Completed________/Last Colonscope________/Bone Density__________

	Yes	No
Do you usually getup to urinate during the night? If yes, # of times:______________________________		
Do you feel pain or burning with urination?		
Any blood in your urine?		
Do you feel burning discharge from penis?		
Has the force of your urination decreased?		
Have you had any kidney, bladder, or prostate infections within the last year?		
Do you have any problems emptying your bladder completely?		
Any difficulty with erection or ejaculation:		
Any testicle pain or swelling?		
Any male breast/chest muscle concerns.		

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OTHER PROBLEMS/CONCERNS

Check if you have or have had any symptoms in the following areas to a significant degree and briefly explain in the space below:

Skin	Chest/heart	Recent changes in:
Head/neck	Back	Weight
Ears	Intestinal	Energy level
Nose	Bladder	Ability to sleep
Throat	Bowel	Other pain/discomfort
Lungs	Circulation	Other odd symptom

Use this space to elaborate on the above chart or for anything else you would like to add not addressed in this form.

Name of Preferred Pharmacy: ________________________/Location or City_______________________________________

Pharmacy Phone Number:______________________________/Fax Number:______________________________________

Patient Signature: ____ Date:______________________________

Provider Signature:____Date:______________________________