

Patient Health History

Name: _____ Today's Date: _____

Parent's Name (if patient is a child): _____

Age: _____ Birth Date: _____ Gender: M F Marital Status: _____

Live with: ___ spouse ___ parents ___ relatives ___ friends ___ alone ___ other
Do you have children? Y N If yes, please include name, age and sex of each child:

Street Address: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____ E-mail: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

How did you hear about Green Mountain Medicine? _____

1. Are you currently receiving health care? Y N From whom: _____
When and where did you last receive health care, and for what reason? _____

2. Please identify the health concerns that brought you to the clinic today (in order of significance):
Condition Past Treatment

3. When did your health complaints begin and what do you think caused them?

4. General State of Health (circle one): Good Fair Poor Comments: _____

5. Do you have any expectations of your first visit to Green Mountain Medicine? (Please list)

6. Do you have any long-term expectations of working with Green Mountain Medicine? (Please list)

7. Do you have any expectations of me personally as your doctor? (Please list)

Patient Name: _____ Date: _____

Family History (cont.):	<u>Mother</u>	<u>Father</u>	<u>Siblings</u>	<u>Spouse</u>	<u>Children</u>
Health (G=good, P=Poor)	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____

For the following, please mark "C" for current experiences and "P" for past experiences:

Emotional

Mood Swings Nervousness Mental Tension Depression

Other: (please specify) _____

Energy and Immunity

Fatigue/Chronic Fatigue Syndrome Slow Wound Healing Chronic Infections

Head, Eye, Ear, Nose, Throat

Impaired Vision Eye Pain/Strain Glaucoma Glasses/Contacts Tearing/Dryness Impaired Hearing

Ear Ringing Earaches Headaches Sinus Problems Nose Bleeds Teeth Grinding

Frequent Sore Throats TMJ/Jaw Problems Hay Fever or Allergies

Respiratory

Pneumonia Frequent Common Colds Difficulty Breathing Emphysema Persistent Cough Pleurisy

Asthma Tuberculosis Shortness of Breath Other: _____

Cardiovascular

Heart Disease Chest Pain Swelling of ankles High Blood Pressure Palpitations Stroke

Heart Murmurs Rheumatic Fever Varicose Veins

Gastrointestinal

Ulcers Changes in Appetite Nausea/Vomiting Abdominal Pain Heartburn Belching

Gas/Bloating Liver Disease Hepatitis B or C Hemorrhoids

Stool

Diarrhea Constipation Undigested Food in Stool Mucous or Blood in Stool

Genito-Urinary Tract

Kidney Disease Painful Urination Frequent Urinary Tract Infections Frequent Urination

Kidney Stones Impaired Urination Urination at night Blood in Urine

Sexually Transmitted Disease(s): (please specify) _____

Female Reproduction

Irregular Cycles Breast Lumps/Tenderness Nipple Discharge Heavy Flow Light Flow Clotting

Bleeding Between Cycles Vaginal Discharge Premenstrual Problems Menopausal Symptoms

Post Menopause Difficulty Conceiving Pain with Intercourse

Menstrual/Birthing History

Age of First Menses: _____ #of Days of Menses: _____ Length of Cycle: _____

Birth Control Now: _____ Birth Control Use in the Past: _____

of Pregnancies: _____ # of Miscarriages: _____ # of Abortions: _____ # of Live Births: _____

Are You Fertile? Y N Age at Menopause _____

Do you have any reason to believe you might be pregnant? Y N

Male Reproductive

Sexual Difficulties Prostate Problems Testicular Pain/Swelling Penile Discharge
 Pain with Intercourse Fertility Problems

Musculoskeletal

Neck/Shoulder Pain Muscle Spasms/Cramps Arm Pain Upper Back Pain Mid Back Pain
 Low Back Pain Leg Pain Joint Pain Other: _____

Neurologic

Vertigo/Dizziness Paralysis Numbness/Tingling Loss of Balance Seizures/Epilepsy

Endocrine

Hypothyroid Hyperthyroid Hypoglycemia Diabetes Mellitus Night Sweats Feeling Hot or Cold
 Hot Flashes

Other

Anemia Cancer (please specify type): _____ Rashes Eczema/Hives Cold Hands/Feet

21. **Lifestyle**

A. **Typical Food Intake**

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

B. **Typical Liquid Intake**

Water intake per day: _____

Other fluid intake per day (please specify type and amount of each): _____

C. **When do you go to sleep?** _____ **When do you wake?** _____

D. **Occupation:** _____ **Employer:** _____

Hours/week: _____

Do you enjoy work? Y N Why/Not? _____

E. **Have you experienced any major traumas or unsettling life experiences (mental, emotional, spiritual, physical) that did, or still affects you deeply?** Y N

Comments: _____

F. **Nicotine/Alcohol/Caffeine/Recreational drug use:** _____

How Often? _____

G. **Exercise:** _____

H. **Hobbies:** _____

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM. This information will be used to guide a thorough evaluation of your health condition and create a health and wellness plan that is personalized to your needs.