New Patient Health History

Holistic Einstein

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Name:_____ Date of Birth:_____

Main Health Concerns Today:

1._____ 3._____

2._____ 4._____

For your most pressing health concern, please describe:

Your current symptoms, with as much detail as possible:

How this affects your life:

What makes this better or worse (medications, activities, therapies, supplements)

What testing or evaluations have been done:

What treatments you have tried for this problem, and how it worked:

Medical History

Please list any past or current medical problems, especially anything that required hospitalization, surgery, or long term medical therapy.

Medications

Please list any medications or supplements you are taking (with dose). If you cannot remember everything you take, please bring a current list, or all your pill bottles, to each and every visit.

Allergies

Please list allergies, especially to medications

Lifestyle

Do you sleep well, and wake up refreshed? If no, why?

How many cups daily of water? milk? coffee? soda? other beverages? (specify)?

How many alcoholic beverages do you drink per week?

Do you smoke? (Y/N) If so, how many packs per day?

Any other drug use?

How much exercise per week (what kind?)

What do you do for fun?

What do you do for work?

Who lives with you (e.g. spouse, children, pets?)

Diet

Please list what you ate on your most recent work day:
Breakfast:

Lunch:

Dinner:

Snacks:

Please list what you ate on your most recent day off:
Breakfast:

Lunch:

Dinner:

Snacks:

Preventative Medicine

When was your most recent Cholesterol Check? Colonoscopy? Tetanus Shot?

Sexually Transmitted Disease Check? PapK ! ōy2ℕY l·f t l·LJ?

Family Medical History

Please list any medical problems, including anything they take medication for

Mother

Father

Siblings

Children

Review of Symptoms Check of any of these symptoms you have had in the last 2 weeks.

GENERAL:

☐ weight gain ☐ weight loss ☐ tired/weak ☐ dizzy/fainting ☐ fever/chills ☐ night sweats

HEAD:

☐ headaches ☐ head trauma ☐ hearing loss ☐ noise in ears ☐ earaches
☐ eye pain ☐ vision loss ☐ itchy eyes ☐ blurry vision ☐ cataracts
☐ painful teeth ☐ dentures ☐ bleeding gums ☐ nosebleeds ☐ runny/ stuffy nose
☐ sore throats ☐ swollen glands ☐ voice change ☐ room spins ☐ hearing aids
☐ wear glasses/contacts

RESPIRATORY:

☐ cough (w/plegm? w/blood?) ☐ wheezing ☐ short of breath ☐ other trouble breathing

HEART & CIRCLATION:

☐ chest pain ☐ heart races or skips beats ☐ short of breath after climbing steps
☐ high blood pressure ☐ legs swell ☐ short of breath while lying in bed
☐ varicose veins ☐ heart murmur ☐ legs hurt or cramp when walking
☐ dizzy when standing up ☐easy bruising/bleeding

DIGESTIVE:

☐ trouble swallowing ☐ heartburn ☐ poor appetite ☐ indigestion ☐ nausea
☐ vomiting (w/blood?) ☐ diarrhea ☐ constipation ☐ change in stool size or color
☐blood in stool ☐ hemorrhoids ☐ rectal pain ☐ excess belching or passing gas
☐ more than 5 bowel movements daily ☐ less than 1 bowel movement every other day

URINARY:

☐ burning with urination ☐ frequent urination ☐ slow/weak urine stream ☐ blood in urine
☐ accidentally lose urine ☐ kidney stones ☐ up multiple times at night to urinate
☐ frequent urinary infection

MUSCULOSKELETAL:

☐ pain in muscles ☐ pain in joints ☐ swollen joints ☐ redness around joints ☐ arthritis
☐ morning stiffness ☐ back pain ☐ gout ☐muscle spasms ☐ scoliosis

NEUROLOGICAL:

☐ blackouts ☐ seizures ☐ numbness or loss of sensation ☐ tingling or "pins and needles"
☐ tremors or other involuntary movements ☐ weakness in arms or legs ☐ trouble walking

SKIN:

☐ rash ☐ hair loss ☐ itching ☐ skin pain ☐ moles ☐ sores ☐ nail changes (specify:)

ENDOCRINE:

☐ heat or cold intolerance ☐ excessive sweating ☐ excessive thirst/hunger ☐excessive urination

PSYCHIATRIC

☐ nervousness ☐ tension ☐depression ☐ difficulty with memory ☐ hallucinations

MALE PATIENTS:

☐ lumps or pain in testicles ☐ erection problems ☐ discharge from penis ☐ poor sex drive

FEMALE PATIENTS:

☐ heavy bleeding ☐ painful periods ☐PMS ☐ painful intercourse ☐ vaginal sores or discharge
☐ breast lumps ☐ nipple discharge ☐ breast tenderness or pain ☐ hot flashes

Age your periods began: Number of days period lasts: Date of last period:
Number of pregnancies: Number of live births: Age at menopause:

BOTH SEXES:

☐ poor sex drive Birth control method: