



105 Tenpenny St
Freeport, ME 04032

219 Mill St.
Rockport, ME 04856

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 many bowel movements per day? How are they (hard/soft/straining)?

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:

Do you have trouble digesting any foods?

Have you noticed any foods giving you bad reactions?

Preventative Medicine

When was your most recent Cholesterol Check?

Colonoscopy?

Tetanus Shot?

Sexually Transmitted Disease Check?

Pap?

Abnormal Pap?

Mammogram?

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 & CIRCULATION:

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
 5+ bowel movements daily less than 3 bowel movements weekly undigested food in stool

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 Birth control method:

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: _____

Birth control method: _____