



Please fill out and return.

Health Status Interview

Client Note: This is a confidential record of your medical history. It will not be released except when you have authorized me to do so.

Name: _____ Date: _____

Birth date: _____ Age: _____ Sex: M F Email: _____

Address: _____ Email: _____

Hm Phone: _____ Wk Phone: _____ Cell: _____

May we leave confidential voice mail at any of the above numbers? Yes / No If yes, please specify which...

Occupation: _____ Employer: _____

Hours of work per week: _____ Retired

Name of Emergency contact: _____ Phone: _____

Name of Spouse or Partner: _____

Married Separated Divorced Widowed Single Partnership

How did you hear about this clinic? _____

List the most important health concerns in order of their significance to you.

1. _____

2. _____

3. _____

4. _____

5. _____

Are you currently receiving healthcare anywhere else? Yes / No

If yes, where and from whom? _____

If no, when and where did you last receive medical or health care? _____

Do you have any contagious diseases at this time? Yes / No

If yes, what? _____

Weight _____ Weight 1 year ago _____ Maximum Weight _____ when? _____

Height _____ Desired weight _____

Date of last physical exam? _____

Personal Habits

Do you eat three meals per day? YES NO

How many hours of sleep per night? _____

Do you wake up feeling rested? YES NO

Do you spend time outside? YES NO

Have a supportive relationship? YES NO

Do you take vacations? YES NO

Had any major traumas? YES NO

Have a history of abuse? YES NO

Do you drink coffee? YES NO

Do you drink black tea? YES NO

Do you drink cola? YES NO

Do you eat sugar? YES NO

Do you go on diets often? YES NO

Do you use Alcohol? YES NO

How often? _____

How much? _____

Do you use recreational drugs? YES NO

How often? _____ What types? _____

Religious or spiritual practice? YES NO

Do you enjoy your job? YES NO

Do you sleep well? YES NO

Do you read? YES NO hrs/wk? _____

Do you watch TV? YES NO hrs/wk? _____

Do you smoke? YES NO packs/wk? _____

Smoke previously? YES NO Years? _____

packs/wk? _____

Do you eat out often? YES NO

Do you eat salt? YES NO

Do you exercise? YES NO

How often and what type? _____

List the **medications** that you are currently taking, including dosage

Be sure to include things such as: Laxatives, Cortisone, Tranquilizers, Pain Reliever, Appetite suppressants, Thyroid medications, Antacids, Antibiotics, Sleeping pills and Birth Control Pills.

List all **vitamins, minerals, herbs, and homeopathic remedies** you are currently taking

Typical Daily Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

If you know your blood type, please tell us: _____

Family Health History

Childhood Illnesses that you have had:

- Scarlet fever Diphtheria Rheumatic fever Mumps
 Measles Chicken pox German Measles

Immunizations that you have had:

- Polio Pertussis Tetanus shot Diphtheria
 Measles/Mumps/Rubella Other _____

	Self	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)	___	___	___	___	___	___	___
Health (G = good, P = poor)	___	___	___	___	___	___	___
Age at death (if deceased)	___	___	___	___	___	___	___
Cause of death	_____						

X' those that are applicable:

Cancer	___	___	___	___	___	___	___
Diabetes	___	___	___	___	___	___	___
Heart Disease	___	___	___	___	___	___	___
High Blood Pressure	___	___	___	___	___	___	___
Stroke	___	___	___	___	___	___	___
Epilepsy	___	___	___	___	___	___	___
Mental Illness	___	___	___	___	___	___	___
Asthma	___	___	___	___	___	___	___
Hayfever	___	___	___	___	___	___	___
Hives	___	___	___	___	___	___	___
Anemia	___	___	___	___	___	___	___
Kidney disease	___	___	___	___	___	___	___
Glaucoma	___	___	___	___	___	___	___
Tuberculosis	___	___	___	___	___	___	___
Alcoholism	___	___	___	___	___	___	___

X-Rays and Special Studies

Please list any Electrocardiograms, electroencephalograms, x-rays, CAT scans, MRIs or other studies you have had done. _____

Hospitalization and Surgeries

Please list any hospitalizations and/or surgeries that you have had: _____

Allergies

To any drugs? _____

To any foods? _____

To any environmental pollens/grasses? _____

Other? _____

Endocrine (Please circle YES- I have this now, NEVER- had, PAST- had in the past.)

Hypothyroid?	YES	NEVER	PAST	Heat or cold intolerance?	YES	NEVER	PAST
Hypoglycemia?	YES	NEVER	PAST	Diabetes?	YES	NEVER	PAST
Excessive thirst?	YES	NEVER	PAST	Excessive hunger?	YES	NEVER	PAST
Fatigue?	YES	NEVER	PAST	Seasonal depression?	YES	NEVER	PAST
Unexplained weight loss?	YES	NEVER	PAST	Easy weight gain?	YES	NEVER	PAST
Poor appetite?	YES	NEVER	PAST				

Immune

Slow wound healing?	YES	NEVER	PAST	Reactions to vaccinations?	YES	NEVER	PAST
Chronic fatigue syndrome?	YES	NEVER	PAST	Chronic infections?	YES	NEVER	PAST
Chronically swollen glands?	YES	NEVER	PAST				

Neurological

Seizures?	YES	NEVER	PAST	Paralysis?	YES	NEVER	PAST
Muscle weakness?	YES	NEVER	PAST	Numbness or tingling?	YES	NEVER	PAST
Loss of memory?	YES	NEVER	PAST	Easily stressed?	YES	NEVER	PAST
Vertigo?	YES	NEVER	PAST	Loss of balance?	YES	NEVER	PAST
Dizziness?	YES	NEVER	PAST	Lightheaded?	YES	NEVER	PAST
Trembling hands/feet?	YES	NEVER	PAST	Poor concentration?	YES	NEVER	PAST
Mood swings?	YES	NEVER	PAST	Slurred speech?	YES	NEVER	PAST

Head

Headaches?	YES	NEVER	PAST	Head injury?	YES	NEVER	PAST
Migraines?	YES	NEVER	PAST	Jaw/TMJ problems?	YES	NEVER	PAST
Lightheadedness?	YES	NEVER	PAST	Loss of balance?	YES	NEVER	PAST
Dizziness?	YES	NEVER	PAST				

Skin

Rashes?	YES	NEVER	PAST	Eczema?	YES	NEVER	PAST
Hives?	YES	NEVER	PAST	Dryness?	YES	NEVER	PAST
Acne, boils?	YES	NEVER	PAST	Itching?	YES	NEVER	PAST
Color changes?	YES	NEVER	PAST	Perpetual hair loss?	YES	NEVER	PAST
Lumps?	YES	NEVER	PAST	Night sweats?	YES	NEVER	PAST
Ulceration?	YES	NEVER	PAST	Sores?	YES	NEVER	PAST
Shingles?	YES	NEVER	PAST	Change in hair/nails?	YES	NEVER	PAST

Eyes

Spots in Eyes?	YES	NEVER	PAST	Cataracts?	YES	NEVER	PAST
Impaired vision?	YES	NEVER	PAST	Glasses/Contacts?	YES	NEVER	PAST
Blurriness?	YES	NEVER	PAST	Eyestrain?	YES	NEVER	PAST
Color blindness?	YES	NEVER	PAST	Tearing or dryness?	YES	NEVER	PAST
Double vision?	YES	NEVER	PAST	Glaucoma?	YES	NEVER	PAST
Eye pain?	YES	NEVER	PAST	Night blindness?	YES	NEVER	PAST
Swollen eyes?	YES	NEVER	PAST	Circles under Eyes?	YES	NEVER	PAST

Ears

Impaired hearing?	YES	NEVER	PAST	Ringing in ears?	YES	NEVER	PAST
Ear aches/Itch?	YES	NEVER	PAST	Excessive ear wax?	YES	NEVER	PAST

Nose & Sinuses

Frequent Colds?	YES	NEVER	PAST	Nose Bleeds?	YES	NEVER	PAST
Stuffiness?	YES	NEVER	PAST	Sinus Problems?	YES	NEVER	PAST
Post Nasal Drip?	YES	NEVER	PAST	Hayfever Allergies?	YES	NEVER	PAST
Loss of Smell?	YES	NEVER	PAST				

Neck

Pain or Stiffness?	YES	NEVER	PAST	Lumps?	YES	NEVER	PAST
Swollen glands?	YES	NEVER	PAST	Goiter?	YES	NEVER	PAST

Mouth & Throat

Frequent sore throat?	YES	NEVER	PAST	Sore Tongue?	YES	NEVER	PAST
Sores in mouth?	YES	NEVER	PAST	Gum problems?	YES	NEVER	PAST
Hoarseness?	YES	NEVER	PAST	Dental Problems?	YES	NEVER	PAST
Difficulty Swallowing?	YES	NEVER	PAST	Difficulty Speaking?	YES	NEVER	PAST
Loss of Taste?	YES	NEVER	PAST	Dental Cavities?	YES	NEVER	PAST
Teeth Grinding?	YES	NEVER	PAST	Jaw Clicks?	YES	NEVER	PAST
Sore Lips?	YES	NEVER	PAST	Copious saliva?	YES	NEVER	PAST

Respiratory

Cough?	YES	NEVER	PAST	Sputum?	YES	NEVER	PAST
Spitting up blood?	YES	NEVER	PAST	Bronchitis?	YES	NEVER	PAST
Wheezing?	YES	NEVER	PAST	Pleurisy?	YES	NEVER	PAST
Difficulty breathing?	YES	NEVER	PAST	Emphysema?	YES	NEVER	PAST
Pain with breathing?	YES	NEVER	PAST	Pneumonia?	YES	NEVER	PAST
Shortness of breath?	YES	NEVER	PAST	Asthma?	YES	NEVER	PAST
- While lying down?	YES	NEVER	PAST	Positive TB test?	YES	NEVER	PAST
- At night?	YES	NEVER	PAST				

Cardiovascular

Heart Disease?	YES	NEVER	PAST	Angina?	YES	NEVER	PAST
High/Low Blood Pressure?	YES	NEVER	PAST	Murmurs?	YES	NEVER	PAST
Blood Clots?	YES	NEVER	PAST	Fainting?	YES	NEVER	PAST
Phlebitis?	YES	NEVER	PAST	Palpitations/Fluttering?	YES	NEVER	PAST
Rheumatic Fever?	YES	NEVER	PAST	Chest Pain?	YES	NEVER	PAST
Swelling in ankles?	YES	NEVER	PAST	Stroke/Heart Attack?	YES	NEVER	PAST

Urinary

Pain on urination?	YES	NEVER	PAST	Increased frequency?	YES	NEVER	PAST
Frequency at night?	YES	NEVER	PAST	Unable to hold urine?	YES	NEVER	PAST
Bladder Infections?	YES	NEVER	PAST	Kidney stones?	YES	NEVER	PAST
Unable to urinate?	YES	NEVER	PAST				

Gastrointestinal

Trouble swallowing?	YES	NEVER	PAST	Black Stools?	YES	NEVER	PAST
Jaundice?	YES	NEVER	PAST	Diverticulitis/losis?	YES	NEVER	PAST
Nausea?	YES	NEVER	PAST	Liver disease?	YES	NEVER	PAST
Vomiting blood?	YES	NEVER	PAST	Heartburn?	YES	NEVER	PAST
Blood in stool?	YES	NEVER	PAST	Change in appetite?	YES	NEVER	PAST
Pain or cramps?	YES	NEVER	PAST	Vomiting?	YES	NEVER	PAST
Belching or passing gas?	YES	NEVER	PAST	Diarrhea?	YES	NEVER	PAST
Gallbladder disease?	YES	NEVER	PAST	Constipation?	YES	NEVER	PAST
Ulcers?	YES	NEVER	PAST	Hemorrhoids?	YES	NEVER	PAST
Stomach pain?	YES	NEVER	PAST	Change in thirst?	YES	NEVER	PAST
Bowel movement how often? _____				Colitis?	YES	NEVER	PAST
Is this a change? _____				Hiatal hernia?	YES	NEVER	PAST

Circulation

Cold hands/feet?	YES	NEVER	PAST	Varicose veins?	YES	NEVER	PAST
Deep leg pain?	YES	NEVER	PAST	Anemia?	YES	NEVER	PAST
Easy bleeding/bruising?	YES	NEVER	PAST	Thrombophlebitis?	YES	NEVER	PAST

Musculoskeletal

Joint pain or stiffness?	YES	NEVER	PAST	Broken bones?	YES	NEVER	PAST
Muscle spasms/cramps?	YES	NEVER	PAST	Back/Neck pain?	YES	NEVER	PAST
Weakness?	YES	NEVER	PAST	Arthritis?	YES	NEVER	PAST

Emotional

Depression?	YES	NEVER	PAST	Tension?	YES	NEVER	PAST
Mood Swings?	YES	NEVER	PAST	Suicidal thoughts?	YES	NEVER	PAST
Treated for emotions?	YES	NEVER	PAST	Anxiety/nervousness?	YES	NEVER	PAST

Menstrual History

Age at onset of menses?_____ Date of last PAP smear?_____ Was it normal? YES NO

Do you have any difficulty with gyn exam? YES NO

First day of last menstrual period:_____

Number of days between 1st day of one period and the 1st day of the next? _____

How many days does your period last? _____

Are your cycles regular? YES NO Do you bleed between cycles? YES NO

Any clotting? YES NO

Do you have any problems with:

Premenstrual tension?	YES NO	Pain?	YES NO
Heavy bleeding?	YES NO	Irregularity?	YES NO
Bleeding between periods?	YES NO	Breast pain/tenderness?	YES NO
Cramping?	YES NO	Abnormal PAPs?	YES NO

Pregnancy History

No. of pregnancies_____ No. of miscarriages? _____

No. of tubal/ectopic pregnancies? _____ Any difficulty conceiving? YES NO

No. of live births_____ No. of abortions? _____

Any complications of pregnancy?_____

Birth Control History

Are you sexually active? YES NO Sexual Orientation? _____

If yes, what birth control are you currently using?_____

What birth controls have you used in the past (please include dates)?

Birth control pills YES NO What kind?_____

IUD YES NO What kind?_____

Cervical Cap YES NO What kind?_____

Sponges YES NO Condoms YES NO Foam YES NO

Diaphragm YES NO Other:_____

Any problems encountered?_____

Any hormone medications used?_____

Pro vera YES NO DES YES NO Estrogen YES NO

Steroids YES NO Morning After Pill YES NO Thyroid meds YES NO
 Cortisone Yes or No Other: _____

Women's General History

Do you do self-breast exams? YES NO How Often? _____

Do you have any pain with intercourse? YES NO

Do you have any problems with:

Endometriosis?	YES NO	Cancer?	YES NO
Pelvic Inflam. Disease?	YES NO	Hot Flashes?	YES NO
Difficulty Conceiving?	YES NO	Cervical dysplasia?	YES NO
Nipple discharge?	YES NO	Bladder infections?	YES NO
Breast lumps/tumors?	YES NO	Hysterectomy?	YES NO
Sexual difficulties?	YES NO	Cervical abnormality?	YES NO
Menopausal symptoms?	YES NO	Uterine abnormality?	YES NO
Bleeding/clotting problems?	YES NO	Ovarian cysts?	YES NO
Sexually Trans. Disease?	YES NO	Vaginal discharge?	YES NO

- If yes, circle which ones:

Herpes Venereal Warts Gonorrhea Chlamydia
 Syphillus Trichomonas Vaginal Infections

Is there anything else? _____

Men's Health History

Hernias?	YES NEVER PAST	Testicular Masses?	YES NEVER PAST
Penile pain?	YES NEVER PAST	Testicular pain?	YES NEVER PAST
Erectile difficulty?	YES NEVER PAST	Testicular swelling?	YES NEVER PAST
Penile discharge?	YES NEVER PAST	Prostate problems?	YES NEVER PAST
Sexually active?	YES NEVER PAST	Sexual Orientation?	YES NEVER PAST
Do you use protection?	YES NEVER PAST	Premature ejaculation?	YES NEVER PAST
- If yes, what type? _____		Monogamous relationship?	YES NEVER PAST
Impotence?	YES NEVER PAST	Any penile sores?	YES NEVER PAST
History of inguinal hernia?	YES NEVER PAST		

Sexually Transmitted disease? YES NO

- If yes, circle which ones:

Chlamydia Gonorrhea Condyloma Herpes Syphillis Venereal warts

Hobbies & Interests

What are your main interests and hobbies? _____

What do you enjoy the most in life? _____

Your Opinions About Your Health

How does your condition affect you? _____

What do you think is happening? _____

Why do you think this is happening to you? _____

What do you feel needs to happen for you to get better? _____

Is there any additional information about your health that you would like to add?

How much change are you willing to make at this time for improving your health?

circle one: MINIMAL SOME COMPLETE

Thank you.

Welcome to Joy of Life Family Medicine.

If you have any question, please ask us.