Health History Intake Form

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Name____Date________________
Age_________Date of Birth_____________________________Gender______________
Address____
City_______________________________State_______________Zip_______________
Home Phone_________________________Work/Cell Phone________________________
Number where it's ok to leave a message about your care__________________________
Occupation______________________________Employer_________________________
Employment status: □full-time □Part-time □Student □Retired

Please circle:
Are you: married, divorced, single, significant partnership
Live with: spouse, partner, relatives, parents, friends, alone, pets

Emergency contact person______________________________Relation______________
Address____Phone________________

How did you hear about Dr. Cory?

What are your current health concerns?
1.____
2.____
3.____

List any Allergies to drugs, foods, supplements, pollens, etc: ______________________
____
____

Please list all medications, supplements and products you are taking

MEDICATION/PRODUCT DOSE REASON

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____
List the names of any others____

Current/Recent Health Care Providers

Name	Dates	Care Provided

Hospitalizations/Operations

Dates	Hospital	Diagnosis	Doctor

Family History

Member	Living?	Age?	Important Diseases Alcoholism, high blood Pressure, cancer, diabetes Heart disease, osteoporosis, Stroke, thyroid, other illness	Cause of Death&Age
Mother				
Father				
Sister(s)				
Brother(s)				
Maternal Grandmother				
Paternal Grandmother				
Maternal Grandfather				
Paternal Granfather				
Maternal Aunt/Uncle(s)				
Paternal Aunt/Uncle(s)				

Personal History

General Health: □Excellent □Good □Fair □Poor

Have you had your cholesterol checked? __________Date___________Results________

Have you had a colonoscopy? __________________Date___________Results________

Have you had a mammogram? _________________ Date___________Results________

Have you had a bone density test?_______________Date___________Results________

Have you had a heavy metal test? _______________Date___________Results________

Childhood diseases: □German measles □Chicken pox other_____________

Past Medical Conditions: (list present conditions in the section below)

□Heart trouble_________________ □Stroke □Varicose veins □Phlebitis

□High blood pressure □Diabetes □Clotting defects □Bleeding tendencies

□Kidney trouble □Rheumatic fever □Jaundice/hepatitis □Epilepsy

□Fractures__________________________ □Cancer___________________________

□Arthritis □Colitis □Asthma □Eating disorder □Anxiety

□Sexually transmitted infections □Anemia □Thyroid problem______________

Review of Systems

Check any symptom of present significance (If any past problems please note above)

General:

□Fevers or chills □Hot flashes □Unusual hair growth □Weight change

□Skin eruptions □Joint pain/changes □Numbness/tingling____________

Abdomen:

□Bloating □Heart burn □Cramps/pain □Diarrhea □Change in bowels

□Bloody stools □Nausea/vomiting □Constipation □Hemorrhoids □Other________

Head:

□Headache □Dizziness □Visual defects □Hearing defects □Sinus trouble □Fainting

Bladder:

□Frequent urination □Painful urination □Blood in urine □Incontinence

Chest:

□Chest pain □Shortness of breath □Heart murmur □Palpitations □Cough

□Wheezing □Coughing up blood □Mitral valve prolapse

Breasts:

□Lumps □Bleeding □Discharge □Tenderness

Females:

Last period began________________________ Last pelvic exam_____________

Date Prior period began__________________ Last PAP smear______________

Have you ever had an abnormal pap?________ When________ Results________

□Abnormal menstrual bleeding (explain_______________________________________

□Painful period □Pain with intercourse □Vaginal discharge or itching

□Sexually transmitted infection □DES exposure □Sexually active

□Safe sex practice Are you trying to get pregnant?___________________________

Birth control method___________________________

Habits

Dietary preferences/restrictions ____
____

Breakfast____

Lunch____

Dinner____

Drink____

Alcohol use (how much)?___________________________how often?_______________

Caffeine use (how much)?___________________________how often?______________

Tobacco use (how much)?___________________________How often?______________

Physical exercise: Type?____________________________How often?______________

Environment

□Water filter □Air filter □Organic foods □Recycles

□Non-toxic cleaning and personal care products

Do you have silver fillings?___________How many?___________________________

When did you last see the dentist?______________What for?_____________________

How often do you eat fish?____________________type_________________________

Is there mold where you live?_________________________

Stresses

List the types of stresses you have in your life (family, work, relationship, self, health etc)

____

____

____

____

How do you handle stress?____

Anything else you want to tell me about your health? _____________________________

____

____

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