## MSN Healthcare, P.C./Mark S. Neumann, D.O. Personal Health History

			1	Jemogi	aphic Infor	mation		
Name (last, first, MI)				Social Security No.				Birthdate
Age	Age Sex Marital Status M / S / D			Home Phone		W (	Work Phone	
Home Ac	ldress (street, city.	, state and z	ip code)		Cell F ( Email	Phone ) Address	,	
Employe	r				ob Title			
Emergen	cy Contact (Name	2)	Contact (I	Phone)	one) Who referred you?			u?
Personal	Physician (Name	and Addres	s) OfficeP	hone:		Prefe	erred Pharm	acy Name/Phone
	This section is of the following	g question	s to the bes	t of your Reason	knowledge.	tation	ry. Please	read and answer all

Plast Medical History  Please check any medical conditions or health problems that you currently have or have had in the past Headaches (Migraines, other)  Past Medical History  Please check any medical conditions or health problems that you currently have or have had in the past Headaches (Migraines, other)  Pyes O no Heart Disease O yes O no Chest Pain O yes O no Irregular Heart Beat O yes O no High Blood Pressure O yes O no High Blood Pressure O yes O no High Blood Pressure O yes O no Bleeding disorder O yes O no Constipation/diarrhea O yes O no Constipation/diarrhea O yes O no Constipation/diarrhea O yes O no Constipation (Disease O yes O no Menstrual disorders O yes O no Menstrual disorders O yes O no Menstrual disorders O yes O no Reproductive problems O yes O no Reproductive problems O yes O no Reproductive problems O yes O no Prostate problems O yes O no Sexual/Libido problems O yes O no Chronic Indigestion O yes O no Chronic pain problems O yes O no Chronic Muscle or Joint Pain O yes O no Rheumatoid Arthritis O yes O no Artificial joint/implants O yes O no Prosrasis or cezema O yes O no O Steoarish or					
Past Medical History Please check any medical conditions or health problems that you currently have or have had in the past Headaches (Migraines, other)  Seizures Disorder  Qyes Ono Chest Pain Qyes Chest Pain Qyes Chronic Indigestion Qyes Ono Blood Clotting problems Qyes Ono Chost Pain Qyes Ono Chost Pain Qyes Ono Chost Pain Qyes Ono Chost Pain Qyes Ono Blood Clotting problems Qyes Ono Bleeding disorder Qyes Ono Constipation/diarrhea Qyes Ono Constipation/diarr					
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Physician Name  Please Medical History  Please check any medical conditions or health problems that you currently have or have had in the pase december of the problems of the					
Physician Name  Please Medical History  Please check any medical conditions or health problems that you currently have or have had in the pase december of the problems of the					
Plast Medical History  Please check any medical conditions or health problems that you currently have or have had in the past-deadaches (Migraines, other)  Peach and the problems that you currently have or have had in the past-deadaches (Migraines, other)  Peach and the problems that you currently have or have had in the past-deadaches (Migraines, other)  Peach and the problems that you currently have or have had in the past-deadaches (Migraines, other)  Peach and the problems that you currently have or have had in the past-deadaches (Migraines, other)  Peach and the pa		re of a ph	ysician o	r health professional for a m	edical/health
Please check any medical conditions or health problems that you currently have or have had in the pass the deck any medical conditions or health problems that you currently have or have had in the pass the deck any medical conditions or health problems that you currently have or have had in the pass the deck any medical conditions or health problems that you currently have or have had in the pass the deck any medical conditions or health problems that you currently have or have had in the pass the deck any medical conditions or health problems that you currently have or have had in the pass the deck any medical conditions or health problems that you currently have or have had in the pass the deck any medical conditions or health problems that you currently have or have had in the pass the deck any medical conditions or health problems or yes on the deck pain that you currently have or have had in the pass that you currently have or have had in the pass that you currently have or have had in the pass that pass the pass that you currently have or have had in the pass the pass to pass the pass that you currently have or have had in the pass that you currently have or have had in the pass to yes on the decirition of the pass of yes on the pass that you currently have or have had in the pass of yes on the pass that you currently have or have had in the pass of yes on the pass of the pass of yes on the pass of the pass of yes on the pass of the pass of the pass of yes on the pass of the pass of the pass of the pass of yes on the pass of the pass of the pass of yes on the pass of th		st			
Please Medical History Please check any medical conditions or health problems that you currently have or have had in the pass Headaches (Migraines, other)  Description of the pass of the					
Please check any medical conditions or health problems that you currently have or have had in the pass Headaches (Migraines, other) Seizures Disorder Seizures Disorder Seizures Disorder Seizures Disorder Seasonal allergies Seasonal Blood Clotting problems Seasonal allergies Seasonal Blood Clotting problems Seasonal allergies Seasonal					
Headaches (Migraines, other)  Heat Disease  Headaches (Migraines, other)  Heat Disease  Heat Beat Pain  Heat Bea		I	Physician No	ame	
Headaches (Migraines, other)  Heat Disease  Heat Beat (Payes)  Heat Blood Pressure  Heat Beat Heat Beat  Heat Blood Pressure  H	ledical History				
Headaches (Migraines, other)  O yes O no Chest Pain O yes O no O High Blood Pressure O yes Chest Pain O yes O no O High Blood Pressure O yes O no O Blood Clotting problems O yes O no O Stroke/vascular disease O yes Chronic pronchitis O yes O no Chest Pain O yes O no O High Blood Pressure O yes O no O Stroke/vascular disease O yes O no Constipation/diarrhea O yes Chronic bronchitis O yes O no Constipation/diarrhea O yes Chronic Indigestion O yes O no Chronic Indigestion O yes O no Chronic Indigestion O yes O no Chronic problems O yes Chronic Pain O yes O no Chronic pain problems O yes Chronic Muscle or Joint Pain O yes O no Chronic Muscle or Joint Pain O yes O no Chronic Muscle or Joint Pain O yes O no Chronic Muscle or Joint Pain O yes O no Chronic pain problems O yes Chronic Muscle or Joint Pain O yes O no Chronic pain problems O yes O no C		or health n	roblems tha	nt you currently have or have had i	n the past?
Seizures Disorder  Seizures Disorder  Recurrent sinus infections  Oyes Ono  High Blood Pressure Oyes Ono Oberession Oyes One Oberession Oyes One O					
Recurrent sinus infections  O yes O no  Irregular Heart Beat O yes Seasonal allergies O yes O no O Blood Clotting problems O yes O no O Bleeding disorder O yes O no O Stroke/vascular disease O yes O no O Kidney disease O yes O no O Menstrual disorders O yes O no O Reproductive problems O yes O no O Sexual/Libido problems O yes O no O Sexual/Libido problems O yes O no O Steoarthritis O yes O no O Steoarth	· -	•			O yes O no O yes O no
Seasonal allergies  O yes O no  High Blood Pressure O yes O no  Blood Clotting problems O yes O no		•			•
Psychiatric or Emotional Illness  O yes O no  Blood Clotting problems O yes O no Bleeding disorder O yes O no O Stroke/vascular disease O yes O no O Hepatitis/Liver disease O yes O no O Menstrual disorders O yes O no O Reproductive problems O yes O no O Prostate problems O yes O no O Sexual/Libido problems O yes O no O Sexual/Libido problems O yes O no O Shoulder problems O yes O no O Steoarthritis O yes O no O Steoarthri		•		_	O yes O no
Depression  O yes O no  Bleeding disorder O yes Onstity or excessive stress O yes O no O Stroke/vascular disease O yes O no O Stindarine O yes O no O Menstrual disorders O yes O no O Reproductive problems O yes O no O Sexual/Libido problems O yes O no O Sexual/Libido problems O yes O no O Chronic pain problems O yes O no O Shoulder problems O yes O no O Steoarthritis	=	•			O yes O no
Anxiety or excessive stress  Asthma  Oyes Ono Constipation/diarrhea Oyes Chronic bronchitis Oyes Ono Hepatitis/Liver disease Oyes Chronic Indigestion Oyes Ono Kidney disease Oyes Chronic Indigestion Oyes Ono Reproductive problems Oyes Ono Reproductive problems Oyes Ono Reproductive problems Oyes Ono Reproductive problems Oyes Ono Sexual/Libido problems Oyes Ono Chronic pain problems Oyes Ono Chronic pain problems Oyes Ono Chronic Muscle or Joint Pain Oyes Ono Chronic Muscle Oyes Ono Ch		•			O yes O no
Asthma  Oyes Ono Constipation/diarrhea Oyes Chronic bronchitis Oyes Ono Hepatitis/Liver disease Oyes Chronic Indigestion Oyes Ono Constipation/diarrhea Oyes Oyes Ono Hepatitis/Liver disease Oyes Oyes Oyes Ono Kidney disease Oyes Oyes Oyes Ono Menstrual disorders Oyes Oyes Ono Reproductive problems Oyes Ono Oyes Ono Oyes Ono Oyes Ono Oyes Oyes Oyes Ono Oyes Oyes Ono Oyes Oyes Oyes Ono Oyes Oyes Ono Oyes Oyes Ono Oyes Oyes Oyes Ono Oyes Oyes Oyes Ono Oyes Oyes Ono Oyes Oyes Oyes Oyes Ono Oyes Oyes Oyes Ono Oyes Oyes Oyes Ono Oyes Oyes Oyes Oyes Ono Oyes Oyes Oyes Ono Oyes Oyes Oyes Oyes Oyes Oyes Ono Oyes Oyes Oyes Oyes Oyes Oyes Oyes Oyes		•			O yes O no
Chronic bronchitis  O yes O no  Lung or breathing problems  O yes O no  Chronic Indigestion  O yes O no  Menstrual disorders  O yes  O no  Menstrual disorders  O yes  O no  Menstrual disorders  O yes  O no  Menstrual disorders  O yes  O no  Reproductive problems  O yes  O no  O yes  O yes  O no  O yes  O yes  O no  O yes  O yes  O no  O yes  O ye	excessive stress	-			O yes O no
Lung or breathing problems  O yes O no  Chronic Indigestion  O yes O no  Menstrual disorders  O yes  Stomach Ulcers  O yes O no  Reproductive problems  O yes  O no  Reproductive problems  O yes  O no  Prostate problems  O yes  O no  Back Pain or Sciatica  O yes O no  Chronic pain problems  O yes  O no  Chronic pain problems  O yes  O no  Chronic Muscle or Joint Pain  O yes  O no  Carpal Tunnel Syndrome  O yes  O no  Carpal Tunnel Syndrome  O yes  O no  Carpal Tunnel Syndrome  O yes  O no  Cancer  O yes  O no  Cancer  O yes  O no  Cancer  O yes  O no  O Sexual/Libido problems  O yes  O no  Chronic pain problems  O yes  O no  Chronic pain problems  O yes  O no  Carpal Tunnel Syndrome  O yes  O no  O Steoarthritis  O yes  O no  Cancer  O yes  O no  O Sexual/Libido problems  O yes  O no  Chronic pain problems  O yes  O no  O Steoarthritis  O yes  O no  O Steoarthritis		•		Constipation/diarrhea	O yes O no
Chronic Indigestion  Oyes Ono  Reproductive problems Oyes Intestinal Disease Oyes Ono Oyes On	conchitis			_	O yes O no
Stomach Ulcers  Intestinal Disease  O yes O no  Prostate problems O yes Skin problems/dermatitis O yes O no O yes O no O yes Skin problems/dermatitis O yes O no O ye	eathing problems	O yes C	) no	Kidney disease	O yes O no
Intestinal Disease  Skin problems/dermatitis  Oyes Ono  Sexual/Libido problems  Oyes  Back Pain or Sciatica  Oyes Ono  Tendonitis  Oyes  Herniated Disc  Oyes Ono  Chronic pain problems  Oyes  Neck pain  Oyes Ono  Shoulder problems  Oyes  Chronic Muscle or Joint Pain  Oyes Ono  Carpal Tunnel Syndrome  Oyes Ono  Rheumatoid Arthritis  Oyes  Oyes  Ono  Cancer  Oyes  Thyroid disease  Oyes  Ono  Osteoarthritis  Oyes  Cancer  Oyes  Oyes  Ono  Oyes  Ono  Oyes  Ono  Oyes  Ono  Oyes  Ono  Oyes  Ono  Oyes  Oyes  Ono  Oyes  Ono  Oyes  Oyes  Ono  Oyes  Oyes  Ono  Oyes  Oyes  Oyes  Oyes  Ono  Oyes  Oy	digestion	O yes C	) no	Menstrual disorders	O yes O no
Skin problems/dermatitis  O yes O no  Back Pain or Sciatica  O yes O no  Herniated Disc  O yes O no  Chronic pain problems  O yes  Neck pain  O yes O no  Chronic pain problems  O yes  Neck pain  O yes O no  Shoulder problems  O yes  Carpal Tunnel Syndrome  O yes O no  Cancer  O yes  O yes  O yes  O no  O Sexual/Libido problems  O yes  O yes  O pes  O	Ilcers	O yes C	) no	Reproductive problems	O yes O no
Skin problems/dermatitis  O yes O no  Back Pain or Sciatica  O yes O no  Herniated Disc  O yes O no  Chronic pain problems  O yes  Neck pain  O yes O no  Chronic pain problems  O yes  Neck pain  O yes O no  Shoulder problems  O yes  Carpal Tunnel Syndrome  O yes O no  Cancer  O yes  Thyroid disease  O yes O no  Psoriasis or eczema	Disease	O yes C	) no	Prostate problems	O yes O no
Back Pain or Sciatica  O yes O no  Herniated Disc  O yes O no  Chronic pain problems  O yes  Neck pain  O yes O no  Shoulder problems  O yes  Chronic Muscle or Joint Pain  O yes O no  O Steoarthritis  O yes  Carpal Tunnel Syndrome  O yes O no  Rheumatoid Arthritis  O yes  Fibromyalgia  O yes O no  Artificial joint/implants  O yes  Thyroid disease  O yes O no  Psoriasis or eczema  O yes	ems/dermatitis	O yes C	on (	*	O yes O no
Herniated Disc  O yes O no  Neck pain  O yes O no  Shoulder problems  O yes  Chronic Muscle or Joint Pain  O yes  O no  O Steoarthritis  O yes  Carpal Tunnel Syndrome  O yes  O no  Rheumatoid Arthritis  O yes  O no  O yes  O no  Artificial joint/implants  O yes  Diabetes  O yes  O no  O yes  O yes  O no  O yes  O yes  O yes  O yes  O yes  O yes  O no  O yes  O no  O yes		•		-	O yes O no
Neck pain  O yes O no  Shoulder problems O yes Ono Osteoarthritis O yes Carpal Tunnel Syndrome O yes O no Rheumatoid Arthritis O yes Diabetes O yes O no Osteoarthritis O yes O no Osteoarthritis O yes O no Osteoarthritis O yes O yes O no Osteoarthritis		•			O yes O no
Chronic Muscle or Joint Pain  O yes O no Osteoarthritis O yes Carpal Tunnel Syndrome O yes O no Rheumatoid Arthritis O yes Fibromyalgia O yes O no Artificial joint/implants O yes O no Osteoarthritis O yes O no Osteoarthritis O yes O yes O no Osteoarthritis O yes O no Osteoarthrit		•			O yes O no
Carpal Tunnel Syndrome  O yes O no Rheumatoid Arthritis O yes Gibromyalgia O yes O no Artificial joint/implants O yes O no Cancer O yes O no Psoriasis or eczema O yes					O yes O no
Fibromyalgia  O yes O no  Artificial joint/implants O yes O yes O no Cancer O yes O yes O no O yes O no O yes O no O yes O yes O yes O no O yes O yes O yes O yes O no O yes O yes O yes	-	•			O yes O no
Diabetes O yes O no Cancer O yes Thyroid disease O yes O no Psoriasis or eczema O yes		-			O yes O no
Thyroid disease	51a	•		· · · · · · · · · · · · · · · · · · ·	O yes O no
	00000	•			O yes O no
		•		Psoriasis of eczema	yes y no
Osteoporosis/Osteopenia O yes O no	sis/Osteopenia	yes C	on no		
List any additional health problems not listed	additional health prob	lems not	listed		

List any surgeries/opera when_			
	are currently taking (or		
Medication Name	Date Started	Date Stopped	Dosage (amount/#, daily)
-			
~If any addition	nal medications please attach	ed a separate page list th	ne above info~
Nutritional supplements	, vitamins, herbs, homeo	pathic remedies	
aken			
Medication			
Allergies:			
Environmental/Food			
Allergies:			
	Patient Na	ıme	
Preventive Tests:	Month/Year of last		Test Results if known
Cholesterol	Month/ 1 car of fast	icsi	1 CSI RESUIIS II KIIOWI.
Unolesterol			
Bone density			
, 			
Colonoscopy			
_			
Exercise stress test			

Family History	W	
Heart disease	Write the relationship of the relative(s) with the disease on to yes ono	he adjacent lines
High Blood Pressure	O yes O no	
Diabetes	O yes O no	
Arthritis	O yes O no	
Skin disorders	O yes O no	
Breast Cancer	O yes O no	
Uterine/Ovarian Canc	er <b>Q</b> yes <b>Q</b> no	
Prostate Cancer	O yes O no	
Colon Cancer	O yes O no	
Other Cancer	O yes O no	
•	condition in the family and	
<u>WOMEN</u> ARE YOU PREGNAN	JT? O yes O no First day of last men	strual cycle
Date of last pap/pelvio	·	Results: O normal O
Date of last mammogr abnormal	Results: O normal O	
Do you perform mont	thly self breast exams O yes O no	
	as an barra rray in the most talran barras nos	or oral contraceptives O yes O no
• •	ig of have you in the past taken normones (	of of all continues buves of yes of no

	yes please list oblem					
– Но	ow many pregnancies have you had?How many childre	en?				
На	ave you had a hysterectomy? O yes O no If yes, were your ova	ries removed? O yes O no				
Ha	ave you had any menstrual irregularities? O yes O no if yes explain					
	as your abdominal girth and weight been increasing?	O yes O no				
	TEN  ate of last prostate exam:					
	e you concerned with loss of muscle mass, tone, or strength?	O yes O no				
	ave you had problems with urination (decreased stream, frequent night urination)	O yes O no				
Do	you perform periodic testicular self examination?	O yes O no				
На	as your abdominal girth and weight been increasing?  Patient Name	O yes O no				
	Social History and Personal Health Hall	bits				
>	General (Check all that apply)					
	My health is <b>O</b> excellent <b>O</b> good <b>O</b> fair <b>O</b> poor. My physical fi	tness is <b>O</b> excellent <b>O</b> good <b>O</b> fair (				
	O I am under a lot of stress O I am fatigued all the time O I am with stress	n having difficulty dealing				
	O I practice meditation or other relaxation techniques O I am of	ten sad and blue				
>	Dietary Habits					
	O No special diet habits O Avoids red meat O Minimizes O Vegetarian	s fat O Minimizes Carbs				
	O Emphasize fruits, grains and vegetables O I try to eat a health dairy/cheese	ny diet O I do not eat				
	O I commonly eat at fast food restaurants					
	I commonly consume: O Coffee O Regular soft drinks O Diet O Chips/crackers	t soda O Candy/chocolate				
>	Exercise Habits					
	O No special exercise habits O I routinely exercisehr(s)X/week					

	Tobacco Use							
	<ul> <li>I never smoked cigarettes or chewed tobacco</li> <li>I now smoke packs of cigarettes per day. I have smoked for years</li> </ul>							
								O I quit smoking in(mo/yr). I smokedpacks/day for years
		O I smoke cigars/pipe						
>	Alcohol Use  O I never drink alcohol  O I drink occasionally or socially							
	O I regularly drink: O 1-2 drinks/day O more than 2 drinks/day O more than 4 drinks/day							
>	Hobbies/Sports/Recreation							
	List routine hobbies/sports/recreational activities							
	Patient Signature							
Da	te							
sho for neo	24 hour notice of cancellation is required. If your cancellation is less than 24 hours or you do not ow for your appointment a rescheduling fee will apply before for your next appointment. This is the consideration of our patients that are waiting for a sooner appointment and allows us the cessary time to contact them with the sooner appointment availability. We thank you for derstanding regarding this policy that has proven to be very successful in meeting our patients							
me	dical needs.							
	actitioner comments on ove							