

MSN Healthcare, P.C.

Personal Health History

Demographic Information

Name (last, first, MI)			Social Security No.		Birthdate
Age	Sex	Marital Status M / S / D	Home Phone ()	Work Phone ()	
Home Address (street, city, state and zip code)			Cell Phone ()		
			Email Address		
Employer			Job Title		
Emergency Contact (Name)		Contact (Phone)		Who referred you?	
Personal Physician (Name and Address)				Preferred Pharmacy Name/Phone	
Office Phone:					

History

This section is for the purpose of learning more about your health history. Please read and answer all of the following questions to the best of your knowledge.

Reason for Consultation

What health concern and symptoms brings you to the clinic?

What would you most like to achieve with this health consultation?

Are you currently under the care of a physician or health professional for a medical/health condition?

Yes No If yes please list condition(s):

Physician Name _____

Past Medical History

Please check any medical conditions or health problems that you currently have or have had in the past?

- | | | | |
|----------------------------------|--|---------------------------|--|
| Headaches (Migraines, other) | <input type="radio"/> yes <input type="radio"/> no | Heart Disease | <input type="radio"/> yes <input type="radio"/> no |
| Seizures Disorder | <input type="radio"/> yes <input type="radio"/> no | Chest Pain | <input type="radio"/> yes <input type="radio"/> no |
| Recurrent sinus infections | <input type="radio"/> yes <input type="radio"/> no | Irregular Heart Beat | <input type="radio"/> yes <input type="radio"/> no |
| Seasonal allergies | <input type="radio"/> yes <input type="radio"/> no | High Blood Pressure | <input type="radio"/> yes <input type="radio"/> no |
| Psychiatric or Emotional Illness | <input type="radio"/> yes <input type="radio"/> no | Blood Clotting problems | <input type="radio"/> yes <input type="radio"/> no |
| Depression | <input type="radio"/> yes <input type="radio"/> no | Bleeding disorder | <input type="radio"/> yes <input type="radio"/> no |
| Anxiety or excessive stress | <input type="radio"/> yes <input type="radio"/> no | Stroke/vascular disease | <input type="radio"/> yes <input type="radio"/> no |
| Asthma | <input type="radio"/> yes <input type="radio"/> no | Constipation/diarrhea | <input type="radio"/> yes <input type="radio"/> no |
| Chronic bronchitis | <input type="radio"/> yes <input type="radio"/> no | Hepatitis/Liver disease | <input type="radio"/> yes <input type="radio"/> no |
| Lung or breathing problems | <input type="radio"/> yes <input type="radio"/> no | Kidney disease | <input type="radio"/> yes <input type="radio"/> no |
| Chronic Indigestion | <input type="radio"/> yes <input type="radio"/> no | Menstrual disorders | <input type="radio"/> yes <input type="radio"/> no |
| Stomach Ulcers | <input type="radio"/> yes <input type="radio"/> no | Reproductive problems | <input type="radio"/> yes <input type="radio"/> no |
| Intestinal Disease | <input type="radio"/> yes <input type="radio"/> no | Prostate problems | <input type="radio"/> yes <input type="radio"/> no |
| Skin problems/dermatitis | <input type="radio"/> yes <input type="radio"/> no | Sexual/Libido problems | <input type="radio"/> yes <input type="radio"/> no |
| Back Pain or Sciatica | <input type="radio"/> yes <input type="radio"/> no | Tendonitis | <input type="radio"/> yes <input type="radio"/> no |
| Herniated Disc | <input type="radio"/> yes <input type="radio"/> no | Chronic pain problems | <input type="radio"/> yes <input type="radio"/> no |
| Neck pain | <input type="radio"/> yes <input type="radio"/> no | Shoulder problems | <input type="radio"/> yes <input type="radio"/> no |
| Chronic Muscle or Joint Pain | <input type="radio"/> yes <input type="radio"/> no | Osteoarthritis | <input type="radio"/> yes <input type="radio"/> no |
| Carpal Tunnel Syndrome | <input type="radio"/> yes <input type="radio"/> no | Rheumatoid Arthritis | <input type="radio"/> yes <input type="radio"/> no |
| Fibromyalgia | <input type="radio"/> yes <input type="radio"/> no | Artificial joint/implants | <input type="radio"/> yes <input type="radio"/> no |
| Diabetes | <input type="radio"/> yes <input type="radio"/> no | Cancer | <input type="radio"/> yes <input type="radio"/> no |
| Thyroid disease | <input type="radio"/> yes <input type="radio"/> no | Psoriasis or eczema | <input type="radio"/> yes <input type="radio"/> no |
| Osteoporosis/Osteopenia | <input type="radio"/> yes <input type="radio"/> no | | |

List any additional health problems not listed above

List any surgeries/operations you have had and when

List any medications you are currently taking (or have taken in the recent past)

Medication Name	Date Started	Date Stopped	Dosage (amount/# daily)

~If any additional medications please attached a separate page list the above info~

Nutritional supplements, vitamins, herbs, homeopathic remedies taken

Medication Allergies:

Environmental/Food Allergies:

Patient Name _____

Preventive Tests:	Month/Year of last test	Test Results if known
Cholesterol	_____	_____
Bone density	_____	_____
Colonoscopy	_____	_____
Exercise stress test	_____	_____

Family History

Write the relationship of the relative(s) with the disease on the adjacent lines

Heart disease yes no

High Blood Pressure yes no

Diabetes yes no

Arthritis yes no

Skin disorders yes no

Breast Cancer yes no

Uterine/Ovarian Cancer yes no

Prostate Cancer yes no

Colon Cancer yes no

Other Cancer yes no

List any other disease/condition in the family and relationship?

WOMEN

ARE YOU PREGNANT? yes no First day of last menstrual cycle _____

Date of last pap/pelvic/breast exam _____ Results: Normal Abnormal

Date of last mammogram _____ Results: Normal Abnormal

Do you perform monthly self breast exams yes no

Are you currently taking or have you in the past taken hormones or oral contraceptives yes no

If yes, please list all hormones and oral contraceptives you have taken and when

Have you ever had any problems or concerns about taking hormone replacement therapy? yes no

If yes please list
problem _____

How many pregnancies have you had? _____ How many children? _____

Have you had a hysterectomy? yes no If yes, were your ovaries removed? yes no

Have you had any menstrual irregularities? yes no *if yes explain*

Has your abdominal girth and weight been increasing? yes no

MEN

Date of last prostate exam: _____

Are you concerned with loss of muscle mass, tone, or strength? yes no

Have you had problems with urination (*decreased stream, frequent night urination*) yes no

Do you perform periodic testicular self examination? yes no

Has your abdominal girth and weight been increasing? yes no

Patient Name _____

Social History and Personal Health Habits

➤ **General** (Check all that apply)

My health is excellent good fair poor. My physical fitness is excellent good fair poor

I am under a lot of stress I am fatigued all the time I am having difficulty dealing with stress

I practice meditation or other relaxation techniques I am often sad and blue

➤ **Dietary Habits**

No special diet habits Avoids red meat Minimizes fat Minimizes Carbs
 Vegetarian

Emphasize fruits, grains and vegetables I try to eat a healthy diet I do not eat dairy/cheese

I commonly eat at fast food restaurants

I commonly consume: Coffee Regular soft drinks Diet soda Candy/chocolate
 Chips/crackers

➤ **Exercise Habits**

No special exercise habits I routinely exercise ____hr(s) ____X/week

Aerobic exercise (jog/walk/treadmill) Lift weights Swim

Stretch/Yoga/Tai Chi/Chi Gong

Other _____

➤ **Tobacco Use**

- I never smoked cigarettes or chewed tobacco
- I now smoke _____ packs of cigarettes per day. I have smoked for _____ years
- I quit smoking in _____ (mo/yr). I smoked _____ packs/day for _____ years
- I smoke cigars/pipe

➤ **Alcohol Use**

- I never drink alcohol I drink occasionally or socially
- I regularly drink: 1-2 drinks/day more than 2 drinks/day more than 4 drinks/day

➤ **Hobbies/Sports/Recreation**

List routine hobbies/sports/recreational activities

Patient Signature Date _____

A 24 hour notice of cancellation is required. If your cancellation is less than 24 hours or you do not show for your appointment a rescheduling fee will apply before for your next appointment. This is for the consideration of our patients that are waiting for a sooner appointment and allows us the necessary time to contact them with the sooner appointment availability. We thank you for understanding regarding this policy that has proven to be very successful in meeting our patients medical needs.

Practitioner comments on above: