MILLER HEALTH AND MEDICAL

NEW PATIENT HISTORY

INFORMATION

NAME_____ AGE_____ DATE_____

ALLERGIES_____ REFERRED BY_____

EMPLOYED BY_____ POSITION_____

PART TIME JOB_____ STUDENT- Y/N SCHOOL_____

MAIN SYMPTOMS

What is the main health problem you are having or what is the purpose of this doctor's appointment?

_____

_____

_____

MEDICAL HISTORY

MEDICATIONS (dosages and # each day) _____

_____

_____

_____

SUPPLEMENTS - VITAMINS, MINERALS, HERBS, HOMEOPATHIES

_____

_____

SURGERIES and YEAR_____

_____

DOCTORS – PREVIOUS AND CURRENT_____

_____

PERSONAL HABITS

Please let us know about your individual lifestyle.

Do you smoke? Cigarettes___ Pipe___ Cigar___ Pot___ Do you use? dip___chew___

Previously or Currently- How much a day?_____ For how long?_____

If you stopped, how long ago was it? _____

How often do you drink alcohol?_____ How much?_____ What kind?_____

How many hours do you sleep?____Do you have trouble going___ or staying___ asleep?

Have you been told that you snore loudly?__or briefly stop breathing while sleeping?___

How often do you have bowel movements?_____Soft___ Hard___ Loose___?

How much caffeine do you drink a day? #___oz. Coffee___ Tea___ Pop___ Diet Pop___

How much water do your drink a day? #___oz. Tap___ Bottled___ Filtered___

Do you attend church? _____. If so, where?_____

How often do you exercise?_____ What type?_____

How many minutes do you exercise?_____ How long have you done this routine? _____

What pets do you have?_____

What do you do to relax or have fun, when you aren't doing house chores, working or taking care of your family?_____

What causes you the most stress in life?_____

FAMILY HISTORY

List which relative, if any, had the following illnesses:

Alcoholism_____ Depression_____

Heart attack_____ Stroke_____ Diabetes_____

Thyroid Disease_____ Other_____

Cancer_____

If any of your immediate family has passed away, explain how they died and when.

_____

PERSONAL INFORMATION

How much education did you complete?_____

What is your marital status? Single Divorced Separated Widowed Married

How many times have you been married?____

How many years for each marriage? 1st_____ 2nd _____ 3rd _____ 4th _____ 5th _____

Name of Spouse or Significant-Other/Live in partner_____

Occupation_____ Employer_____

Children: List the name and ages._____

_____

_____

Grandchildren: List the name and ages._____

_____

_____

MEDICAL PROCEDURES

When did you last have these tests done?

Tests	Never	Where was the test done?
Blood Work_____	_____	_____
EKG _____	_____	_____
Chest X Ray _____	_____	_____
Colonoscopy_____	_____	_____

Please list any other past Procedures and/or Medical Tests

_____

MRI_____

CT _____

EGD_____ ULTRASOUND_____ STRESS TEST_____

FEMALE QUESTIONS

Do you have regular periods?___ Do you have excessive flow?____ heavy cramps?____

How many pads____ or tampons____ do you use on your heaviest days?

How old were you when you started having periods?_____

Do you have any PMS problems before your period like irritability, bloating, anger, cravings?_____ Is so, how many days does it last before your period? _____

What are your emotional or physical PMS symptoms? _____

What was the date of the first day of your last menstrual period?_____

Are you sexually active?_____ If so, what kind of birth control do you use? Nothing___, Birth Control Pills___, DepoProvera Shot___ , Patch___, Condoms___, Diaphragm___, IUD___, Tubal___, Menopause___, Hysterectomy___, Withdrawal___, Vasectomy___.

If you have had surgery, was your uterus removed?____ and your ovaries removed?____

If you had a hysterectomy, was it because of cervical cancer?_____

Have you every had any sexually transmitted diseases?_____

Have you ever had an abnormal pap smear?_____ When?_____

How many times have you been pregnant?___ Births___ Miscarriages___ Abortions___

<u>HORMONE IMBALANCES/DEFICIENCIES</u>

Do you have hot flashes?____ night sweats?____ moodiness?____ irritability?____ acne?____ facial hair?____ problems with memory?____ Other_____

Do you have problems sleeping, that significantly affect your life now?_____

Do you leak urine?____ Do you have dry vagina?____ Is sex painful?_____

Did you used to have PMS before menopause?_____

Do you have less interest in sex?____ Does it cause problems in your life?_____

How often does your partner want sex?_____ Can you orgasm easily?_____

Is your hair thinning?_____ Is it so thin that you can see your scalp?_____

What have you done to correct the thinning hair?_____

When have you had a pap?_____ Never_____

When have you have a mammogram?_____Never_____

When have you had a bone density?_____ Never_____