Integrated Health Center

2324 Post Road • Fairfield, CT 06824 • (203) 259-2700 • Fax (203) 259-3214

NOTES:

Name _____

Address _____

_____

Telephone# ( ) _____

Date of Birth: _____ Referred by: _____

Occupation: _____

Family Physician: _____

Primary Problem #I: _____

When did it start? _____

Describe how it started: _____

_____

Where is the symptom/or pain located? _____

What makes it worse? _____

What makes it better? _____

Problem #2: _____

When did it start? _____

Describe how it started: _____

_____

Where is the symptom/or pain located? _____

What makes it worse? _____

What makes it better? _____

Problem #3: _____

When did it start? _____

Describe how it started: _____

_____

Where is the symptom/or pain located? _____

What makes it worse? _____

What makes it better? _____

Problem #4: _____

When did it start? _____

Describe how it started: _____

_____

Where is the sympton/or pain located? _____

What makes it worse? _____

What makes it better? _____

For additional problems, please list and describe in above format on a separate page.

LIFE STYLE

1. **DIET:** What foods do you crave?

I) _____ when? _____

2) _____ when? _____

3) _____ when? _____

4) _____ when? _____

For additional foods, please list and describe in above format on a separate page.

What foods make you ill? _____

_____

2. EXERCISE:

NOTES:

State number of minutes you devote to exercise DAILY and the type of exercise you do

Type of Exercise	Minutes Per Day

3. RECREATION: What do you do for fun? (Circle)

read dance music meditate art craft

other (name) _____

4. SLEEP HABITS

Hours? _____ Refreshed or tired on waking? _____ Restless? _____ Perspiration? _____

How many covers do you use? _____ Do you throw off covers? _____

5. DREAMS

Describe any recurring dreams: _____

_____

_____

_____

6. PERSPIRATION *Check one*

Do You perspire a lot? _____ If yes, when _____

Or, never perspire? _____ Any odor to your perspiration? _____

What part of the body perspires the most? _____

7. WEATHER PREFERRED *Check one*

❑ Spring ❑ Fall ❑ Summer ❑ Winter

How do you feel in: *Check one*

	not good	good	great
Hot humid weather	❑	❑	❑
Dry hot weather	❑	❑	❑
Thunderstorms	❑	❑	❑
Near the seashore	❑	❑	❑
Changing weather patterns	❑	❑	❑

8. IN GENERAL

Do you feel better in open air? _____ Do you like company? _____

How do you feel when you are consoled? _____

_____

When upset with a situation/person/job, what do you do? *Check one*

❑ talk about it ❑ cry a lot ❑ clam up ❑ get into a rage

❑ other, Explain _____

What is your worst fear/nightmare? _____

_____

_____

How do you feel in a new situation, ie., parties/social events/public speaking? _____

_____

_____

What is your worst time of day or night? _____

_____

What is your best time of day or night? _____

_____

NOTES:

PAST MEDICAL HISTORY

General state of health _____

What When Where

List childhood illnesses _____

_____

_____

List adult illnesses _____

_____

_____

List surgeries _____

_____

_____

List hospitalizations _____

_____

_____

Have you been immunized? _____

List allergies (foods, chemicals, medications, plants, pollens, insects, etc.)

_____

_____

FAMILY HISTORY - *List illness or cause of death*

Mother _____

Father _____

Brother(s) _____

Sister(s) _____

PATERNAL MATERNAL

Grandmother _____

Grandfather _____

Uncles _____

Aunts _____

OTHER _____

PSYCO-SOCIAL HISTORY

Born & raised: (where) _____

Ancestry: _____

Work history _____

_____

Work stress _____

_____

Married _____ Pregnancies _____ Living Children _____ Divorced_____

Committed relationship _____

Any social or financial stress? _____

_____

Additional Comments_____

_____

_____

REVIEW OF SYSTEMS

Please check any symptoms which apply to you:

General:

now past

- ☐ ☐ current weight
- ☐ ☐ recent weight change
- ☐ ☐ weakness
- ☐ ☐ fatigue
- ☐ ☐ fever

Head:

- ☐ ☐ headache
- ☐ ☐ head injury
- ☐ ☐ hair loss or thinning
- ☐ ☐ dry, coarse hair

other _____

Eyes:

- ☐ ☐ nearsightedness or farsightedness
- ☐ ☐ blurred or failing vision
- ☐ ☐ dry, burning or itching eyes
- ☐ ☐ eyes water excessively
- ☐ ☐ eyes sensitive to light
- ☐ ☐ night blindness
- ☐ ☐ bloodshot or puffy eyes

other _____

Ears:

- ☐ ☐ earaches
- ☐ ☐ noises or ringing
- ☐ ☐ ear discharges
- ☐ ☐ loss of hearing
- ☐ ☐ lots of wax
- ☐ ☐ dizziness
- ☐ ☐ infection

other _____

Nose and sinuses:

- ☐ ☐ frequent colds
- ☐ ☐ nasal stuffiness
- ☐ ☐ hay fever
- ☐ ☐ nosebleeds
- ☐ ☐ sinus trouble
- ☐ ☐ nability to smell or taste

other _____

Mouth and throat:

- ☐ ☐ bleeding gums
- ☐ ☐ sore tongue
- ☐ ☐ frequent sore throats
- ☐ ☐ dry or chapped lips
- ☐ ☐ dry mouth
- ☐ ☐ clear throat a lot
- ☐ ☐ lots of cavities
- ☐ ☐ hoarseness
- ☐ ☐ cracks in comers of mouth

other _____

Neck:

- ☐ ☐ lumps in neck
- ☐ ☐ "swollen glands"
- ☐ ☐ goiter
- ☐ ☐ pain in the neck

other _____

Respiratory:

- ☐ ☐ cough
- ☐ ☐ spitting up mucous or blood
- ☐ ☐ difficulty breathing
- ☐ ☐ shortness of breath on exertion
- ☐ ☐ chest pain
- ☐ ☐ wheezing
- ☐ ☐ asthma

Respiratory: *(Cont)*

now past

- ☐ ☐ bronchitis
- ☐ ☐ emphysema
- ☐ ☐ pneumonia
- ☐ ☐ tuberculous
- ☐ ☐ pleurisy

other _____

Cardiac:

- ☐ ☐ heart trouble
- ☐ ☐ rheumatic fever
- ☐ ☐ heart murmurs
- ☐ ☐ difficulty breathing
- ☐ ☐ edema
- ☐ ☐ chest pain
- ☐ ☐ palpitations
- ☐ ☐ tightness in chest
- ☐ ☐ discomfort at high altitudes
- ☐ ☐ dizzy or weak upon standing
- ☐ ☐ swollen feet, ankles or legs
- ☐ ☐ cold hands or feet
- ☐ ☐ hands or feet turn blue
- ☐ ☐ leg pains when walking
- ☐ ☐ varicose veins
- ☐ ☐ tendency to anemia
- ☐ ☐ high blood pressure
- ☐ ☐ low blood pressure

other _____

Gastrointestinal:

- ☐ ☐ trouble swallowing
- ☐ ☐ heartburn
- ☐ ☐ loss of appetite
- ☐ ☐ nausea
- ☐ ☐ vomiting
- ☐ ☐ vomiting of blood
- ☐ ☐ indigestion
- ☐ ☐ constipation
- ☐ ☐ rectal bleeding
- ☐ ☐ black tarry stools
- ☐ ☐ diarrhea
- ☐ ☐ abdominal pain
- ☐ ☐ food intolerance
- ☐ ☐ excessive belching
- ☐ ☐ passing of gas
- ☐ ☐ hemorrhoids
- ☐ ☐ jaundice
- ☐ ☐ liver or gall bladder trouble
- ☐ ☐ hepatitis

other _____

Urinary:

- ☐ ☐ difficulty urinating
- ☐ ☐ blood in urine
- ☐ ☐ urinate frequently at night
- ☐ ☐ incomplete urination or dribbling
- ☐ ☐ pain when urinating
- ☐ ☐ lower back pain
- ☐ ☐ urgency when urinating
- ☐ ☐ hesitancy when urinating
- ☐ ☐ incontinence urinary
- ☐ ☐ infections, stones

Female:

- ☐ ☐ lumps in breasts
- ☐ ☐ pain in breasts
- ☐ ☐ nipple discharge
- ☐ ☐ swollen breasts
- ☐ ☐ self-examination (how often?) _____
- ☐ ☐ irregular menstruation
- ☐ ☐ bleeding between periods or after intercourse
- ☐ ☐ pain prior to or with periods

Female: *(Cont)*

now past

- ☐ ☐ depressed, tense or irritable around periods
- ☐ ☐ diminished or excessive sexual desire
- ☐ ☐ difficulty having orgasm
- ☐ ☐ inability to conceive
- ☐ ☐ miscarriages or abortions
- ☐ ☐ vaginal discharge
- ☐ ☐ pain, discomfort or itching in genital area
- ☐ ☐ hot flashes
- ☐ ☐ menopause
- ☐ ☐ venereal disease
- ☐ ☐ symptoms occur in monthly pattern

_____ age at first menses
_____ frequency of menses
_____ duration of menses
_____ date of last Pap smear
_____ was it normal?
_____ type of birth control

other _____

Male:

- ☐ ☐ prostrate problems
- ☐ ☐ difficult or unusual urination
- ☐ ☐ discomfort or pain in genital area
- ☐ ☐ diminished or excessive sexual desire
- ☐ ☐ difficulty maintaining an erection
- ☐ ☐ discharge from or sores on penis
- ☐ ☐ history of venereal disease
- ☐ ☐ hernias
- ☐ ☐ testicular pain or masses

other _____

Musculoskeletal:

- ☐ ☐ joint pains or stiffness
- ☐ ☐ muscle pains or stiffness

where? _____

- ☐ ☐ arthritis
- ☐ ☐ gout
- ☐ ☐ backache
- ☐ ☐ bone pains
- ☐ ☐ painful feet, ankles or calves
- ☐ ☐ tremors or twitches
- ☐ ☐ loss of strength
- ☐ ☐ hernia
- ☐ ☐ muscle wasting
- ☐ ☐ limitation of motion

where? _____

other _____

Skin:

- ☐ ☐ acne or pimples
- ☐ ☐ hives
- ☐ ☐ rashes
- ☐ ☐ lumps
- ☐ ☐ itching
- ☐ ☐ dryness
- ☐ ☐ color change
- ☐ ☐ changes in hair or nails
- ☐ ☐ skin ulcers or sores
- ☐ ☐ dryness, roughness or scaling skin
- ☐ ☐ bruise easily
- ☐ ☐ moles, warts or skin tags
- ☐ ☐ flush easily
- ☐ ☐ cuts heal slowly or scar badly
- ☐ ☐ feet burn
- ☐ ☐ nails weak, ridged or split

other _____

Peripheral vascular:

now past

- ☐ ☐ tingling in legs or arms
- ☐ ☐ cramps
- ☐ ☐ thrombophlebitis

other _____

Neurological:

- ☐ ☐ fainting
- ☐ ☐ blackouts
- ☐ ☐ seizures
- ☐ ☐ paralysis
- ☐ ☐ local weakness
- ☐ ☐ numbness
- ☐ ☐ tingling
- ☐ ☐ tremors
- ☐ ☐ memory loss

other _____

Psychiatric:

- ☐ ☐ nervousness
- ☐ ☐ tension
- ☐ ☐ mood swings
- ☐ ☐ depression

other _____

Endocrine:

- ☐ ☐ thyroid trouble
- ☐ ☐ heat or cold intolerance
- ☐ ☐ excessive sweating
- ☐ ☐ diabetes
- ☐ ☐ excessive thirst, hunger or urination

other _____

Hematologic:

- ☐ ☐ anemia
- ☐ ☐ easy bruising or bleeding
- ☐ ☐ transfusions

possible reactions _____

Habits:

Do you use any of the following?

- ☐ cigarettes or tobacco ____ packs per day
- ☐ coffee or black tea ____ cups per day
- ☐ alcohol ____ drinks per day/week/year
- ☐ marijuana or other drugs ____ times per week
- ☐ juices ____ glasses per day
- ☐ soda ____ glasses per day
- ☐ water ____ glasses per day
- ☐ milk ____ glasses per day

Supplements and Prescriptions:

(please list below:)

- ☐ Vitamins

_____

_____

- ☐ herbs or homeopathic remedies

_____

_____

- ☐ over the counter medications

_____

_____

- ☐ prescription medications

_____

_____