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## COMPREHENSIVE HEALTH PROFILE

Date \_\_\_\_\_

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: M F Marital status: M S W D P (circle one)

Occupation \_\_\_\_\_ Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Insurance \_\_\_\_\_ SS # \_\_\_\_\_

E-Mail Address \_\_\_\_\_ Referred by \_\_\_\_\_

Nearest friend or relative who may be called in an emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

**Instructions:** Put a check in those boxes applicable to you. When necessary write in your answer.

1) **REASON FOR TODAY'S VISIT:** \_\_\_\_\_

### 2) ILLNESSES / INJURIES

Have you had:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Mumps                       | <input type="checkbox"/> Head injury               | <input type="checkbox"/> Recurring backache                  |
| <input type="checkbox"/> Measles                     | <input type="checkbox"/> Poisoning of any kind     | <input type="checkbox"/> Nervous breakdown                   |
| <input type="checkbox"/> Rubella                     | <input type="checkbox"/> Skin disorders            | <input type="checkbox"/> Diabetes                            |
| <input type="checkbox"/> Chickenpox                  | <input type="checkbox"/> Recurring headaches       | <input type="checkbox"/> Thyroid problems                    |
| <input type="checkbox"/> Whooping cough              | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> List any other illness or injuries: |
| <input type="checkbox"/> Pneumonia                   | <input type="checkbox"/> Asthma                    | <input type="checkbox"/> _____                               |
| <input type="checkbox"/> Rheumatic                   | <input type="checkbox"/> Heart problems            | <input type="checkbox"/> _____                               |
| <input type="checkbox"/> Polio                       | <input type="checkbox"/> High blood pressure       | <input type="checkbox"/> _____                               |
| <input type="checkbox"/> Mononucleosis               | <input type="checkbox"/> Peptic ulcer              | <input type="checkbox"/> _____                               |
| <input type="checkbox"/> Tuberculosis (TB)           | <input type="checkbox"/> Liver/gallbladder disease | <input type="checkbox"/> _____                               |
| <input type="checkbox"/> Venereal disease (VD)       | <input type="checkbox"/> Hemorrhoids               | <input type="checkbox"/> _____                               |
| <input type="checkbox"/> Frequent colds or infection | <input type="checkbox"/> Kidney problems           | <input type="checkbox"/> _____                               |
| <input type="checkbox"/> Any broken bones            | <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> _____                               |

### 3) SURGERY / HOSPITALIZATIONS

Have you had removed:

When?:

- |  |       |
|--|-------|
| <input type="checkbox"/> Tonsils               | _____ |
| <input type="checkbox"/> Appendix              | _____ |
| <input type="checkbox"/> Gallbladder           | _____ |
| <input type="checkbox"/> Uterus (hysterectomy) | _____ |
| <input type="checkbox"/> One or both ovaries   | _____ |

List any operations or periods of hospitalization for any illness

- \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### 4) IMMUNIZATIONS

Have you had any of the following immunizations:

- Polio  
 Diphtheria/ pertussis/ tetanus (DPT)  
 Measles  
 Mumps  
 Smallpox  
 Tetanus booster (last ten years)

List any others:

- \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**5) ALLERGIES**

Are you allergic to any:       Foods                       Drugs or medication                       Other substances

List: \_\_\_\_\_

**6) MEDICATIONS**

Do you regularly take:

- |   |                                     |  |
|---|-------------------------------------|--|
| <input type="checkbox"/> Digestive enzymes          | <input type="checkbox"/> Sedatives  | <input type="checkbox"/> Sleeping pills                    |
| <input type="checkbox"/> Laxatives                  | <input type="checkbox"/> Diet pills | <input type="checkbox"/> Thyroid (grains per day _____)    |
| <input type="checkbox"/> Antacids                   | <input type="checkbox"/> Cortisone  | List any other medications you are currently taking: _____ |
| <input type="checkbox"/> Aspirin and cold medicines | <input type="checkbox"/> Estrogen   | _____  |

**7) HABITS / ENVIRONMENT**

Do you:

- |  |  |
|--|--|
| <input type="checkbox"/> Awaken feeling unrested                           | <input type="checkbox"/> Drink alcohol (how much? _____)     |
| <input type="checkbox"/> Have trouble sleeping                             | <input type="checkbox"/> Drink coffee (cups per day _____)   |
| <input type="checkbox"/> Have problems with constipation                   | <input type="checkbox"/> Smoke tobacco (packs per day _____) |
| <input type="checkbox"/> Exercise: (how much – how often?)                 | Have you been treated for:                                   |
| <input type="checkbox"/> Have problems at work, home                       | <input type="checkbox"/> Alcoholism                          |
| <input type="checkbox"/> Have trouble relaxing or enjoying your spare time | <input type="checkbox"/> Drug abuse                          |
|  | <input type="checkbox"/> Eating disorder                     |

**8) DIET**

Do you:

- |  |  |
|--|--|
| <input type="checkbox"/> Feel your diet is adequate            | <input type="checkbox"/> Regularly drink “softened” water                    |
| <input type="checkbox"/> Eat at irregular intervals            | <input type="checkbox"/> Regularly salt your food                            |
| <input type="checkbox"/> Eat in a hurried atmosphere           | <input type="checkbox"/> Regularly eat fried foods                           |
| <input type="checkbox"/> Eat quickly and forget to chew        | <input type="checkbox"/> Use sugar on your food or in drinks                 |
| <input type="checkbox"/> Eat between meals                     | <input type="checkbox"/> Use sugar in cooking                                |
| <input type="checkbox"/> Drink with meals                      | <input type="checkbox"/> Eat foods with artificial coloring                  |
| <input type="checkbox"/> Eat out often (more than once a week) | <input type="checkbox"/> Or flavoring, preservatives                         |
| <input type="checkbox"/> Follow a special or restricted diet   | List any vitamin, mineral or other dietary supplements you are taking: _____ |
| <input type="checkbox"/> Avoid certain foods                   | _____  |

**9) FAMILY HISTORY**

Which member of your family or near relative had:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Diabetes        | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hives or hay fever |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Arthritis or gout  |
| <input type="checkbox"/> Heart problems  | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Thyroid problems   |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Nervous breakdown   | <input type="checkbox"/> Bleeding problems  |
| <input type="checkbox"/> Cancer          | <input type="checkbox"/> Asthma              | <input type="checkbox"/> Weight problems    |

**10) WOMEN ONLY: MENSTRUAL HISTORY / PREGNANCIES**

Do you have:

- |  |  |
|--|--|
| <input type="checkbox"/> Irregular periods                   | Age onset of menses: _____             |
| <input type="checkbox"/> Cramps or pain with period          | Age at menopause _____                 |
| <input type="checkbox"/> Tension or depression before period | Usual length of cycle: _____ days      |
| <input type="checkbox"/> Breast tenderness before period     | Usual duration of flow: _____ days     |
| <input type="checkbox"/> Hot flashes at any time             | Is your flow: Light    Medium    Heavy |
| <input type="checkbox"/> Pain during intercourse             | Date last period began: _____          |
| <input type="checkbox"/> Any unusual bleeding or discharge   | Date of last PAP: _____                |

Are you:

- |  |                           |
|--|---------------------------|
| <input type="checkbox"/> Pregnant or possibly pregnant     | _____ children born alive |
| <input type="checkbox"/> Having problems getting pregnant  | _____ caesarian sections  |
| <input type="checkbox"/> Using any method of birth control | _____ premature births    |
| What kind: _____   | _____ stillborn           |
|  | _____ miscarriages        |
|  | _____ abortions           |