**Medical History**

**Name _____ Date _____ DOB_____**

**Current/Recent Medical Problems:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**Past Serious Medical Illnesses – and include if hospitalized**

_____
_____
_____

_____
_____
_____

_____
_____
_____

**Are you HIV positive --- Y N** **Are you positive for TB--- Y N**

**Any chronic infectious conditions_____**
**Lymes- Y N In the past _____Other Tick Borne diseases _____**

Recent travel outside the US_____

**Current Medication List, including all OTC's doses and frequencies**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

**Past Medical Issues** **Surgeries- name, date, outcome etc**

_____ _____

_____ _____

_____ _____

_____ _____

**Allergies – list all with reactions**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

**Dates of : Most Recent PE_____Labs_____ EKG_____**
**( please provide copies asap- to avoid unnecessary testing)**

**Some testing may be required in any event**

**Name of Primary Care Physician_____**
**Phone Number of Internist_____**
Do you have a current active medical problem that is being evaluated and not yet diagnosed and treated?_____
_____
Are you receiving other types of physical care, such as acupuncture, naturopathy, or any experimental treatments for any problems at all. _____

**NAME: :** _____ **Today's Date**: _____

## REVIEW OF SYSTEMS: Check anything that has applied for the last 3 months

**Const. (Health in General)** ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other:

_____

**Ears, Nose, Mouth & Throat** ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other:

_____ _____

**C-V (Heart & Blood Vessels)** ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other:

_____

**Resp. (Lungs & Breathing)** ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other:

_____

**GI (Stomach & Intestines)** ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other:

_____

**GU (Kidney & Bladder)** ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

**MS (Muscles, Bones, Joints)** ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other:

_____

**Integ. (Skin, Hair & Breast)** ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other:

_____

**Neurologic (Brain & Nerves)** ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other:

_____

**Endocrinologic (Glands)** ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _____

**Hematologic (Blood/Lymph)** ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other:

_____

**Allergic/Immunologic** ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

_____

**Name_____Date _____Dob_____**

## Women's Medical History Form

**Age of menarche _____Age at Menopause_____**

**1. Since you first began having periods, have you ever had what you would consider to be abnormal cycles? Yes No**

If yes, please explain (such as age, when this occurred, symptoms, etc.)

_____

**2. When was your last period? How many days did it last**? First day of bleeding is day one_____

**3. How many days from the start of one period to another?**_____

**4. Do you have, or did you ever have Premenstrual Syndrome (PMS) or PMDD? Yes No** If yes, please explain symptoms:

_____
_____
_____

**5. Have you experienced recent changes in your normal cycle?** please describe**:**

_____
_____

**6. Do you experience any bleeding between periods?** _____

**7. Do you have PCOS_____ STD's _____Other gyn issues _____**

**8. Are you sexually active_____ # of partners** _____

**9 What is your sexual orientation**_____

**10. Are you pregnant**_____ Have you ever been pregnant_____

**11**. **Are you considering becoming pregnant** _____When _____

**12 Are you using birth control?** _____Type_____

**13. How do you protect yourself from STD's?_____**
_____

_____

**14. Are you fully in menopause_____For how long _____**

**15. Are you in perimenopause____Symptoms_____**

**General Women's Health Form - For Women who still may become pregnant ( Not fully in menopause- Menopause is defined as not having had a period from 12 consecutive months)**

**Please read and sign:**

I, _____, attest that I am not pregnant now or intending to become pregnant. I acknowledge that I am aware that taking psychotropic medications can have a harmful effect on an embryo, fetus, or a baby during breast feeding.
I agree, that if I am planning to become pregnant, I will inform Dr. Paras at our first meeting, and discuss what to do to ensure my unborn child will not be harmed by taking psychotropic medications.
I also agree that I will use effective birth control until such time that I wish to become pregnant, and that I will be vigilant about a possible unplanned pregnancy occurring.
Should I become pregnant, I will inform Dr. Paras as soon as possible and we will discuss my options.

Name_____ Date_____ Dob_____

Signature_____