

Tabor Hill Clinic

Name _____

What is the **main** reason for your visit today? If you have a specific health condition, please describe it in detail. When was the very first time that you noticed your condition? What events or conditions in your life may have influenced or aggravated the condition of your health?

What are your most important health concerns?

1. _____
2. _____
3. _____
4. _____
5. _____

Please describe major health problems, hospitalizations and surgeries (please include dates)

Current/Recent Health Care Providers

Name	Dates	Care Provided	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies you may have (Environmental, food, medications, pets etc.)

What supplements (vitamins, minerals, herbs etc.) do you take?

What over-the counter medicines (like Tylenol, cough syrup, Advil, etc.) do you use and why?

Please list prescription medications:

HABITS

Dietary references/restrictions: _____

Sample of Day's menu (please include approximate time of day of meal):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Daily water consumption – please include quantity and type (eg. Filtered, well water, etc.) _____

Aspartame use (Nutrasweet™, Equal™, soda, chewing gum, gelatin, etc.)? _____ How much? _____

How often? _____

Caffeine use (how much): _____ Alcohol use (how much): _____

Tobacco use (how much): _____ Previously? _____ How much? _____ How long? _____

Mood-altering substance use (i.e. marijuana, cocaine – past and present): _____

What kind of activity or exercise do you do? How often and how long?

How much do you weigh? _____ Is this your typical weight? _____

Have you experienced weight gain or loss recently? Please describe: _____

Do you have pets or plants? Please describe: _____

On a scale of 1-10 (1 is lowest, 10 is highest), describe the level of stress you currently experience:

1 2 3 4 5 6 7 8 9 10

In what areas of life are you experiencing stress?

Family Money/Finances Relationship/Marriage Work Health Children

Other: _____

Please describe when you have used antibiotics and why they were prescribed: _____

Childhood Illnesses - Circle Y for Yes, N for No

Y	N	Chicken Pox	Y	N	Diphtheria
Y	N	Mumps	Y	N	Measles
Y	N	Scarlet fever	Y	N	Polio

Please check any health condition or symptom you have or have had:

Circle C for Current Condition and/or P for Past condition. Leave blank if you have never had the condition.

Respiratory

C P Asthma
 C P Chronic bronchitis
 C P Emphysema
 C P Pain with breathing
 C P Wheezing
 C P Trouble breathing/ Shortness of breath
 C P Shortness of breath lying down

Endocrine

C P Hypothyroid
 C P Hyperthyroid
 C P Low blood sugar (hypoglycemia)
 C P Fatigue
 C P Diabetes (Childhood onset)
 C P Diabetes (Adult onset)
 C P Intolerance to heat or cold
 C P Excessive hunger or thirst

Skin

C P Rashes
 C P Acne/Boils
 C P Color change(s)
 C P Sunburn _____no.of times _____severity
 C P Eczema, hives
 C P Itching
 C P Hair loss
 C P Night sweats

Nose & Sinuses

C P Stuffiness/post nasal drip
 C P Hayfever
 C P Nasal polyps
 C P Frequent sore throat
 C P Sinus infections
 C P Nose bleeds
 C P Loss or change of sense of smell

Immune System

C P Chronic fatigue syndrome
 C P Swollen glands
 C P Frequent colds/flu
 C P Chronic infections
 C P Wounds heal slowly

Cardiovascular

C P Heart disease
 C P Heart attack
 C P Angina
 C P Heart murmur
 C P High/Low blood pressure
 C P High cholesterol/low cholesterol
 C P Heart palpitations
 C P Chest pain

Neurological

C P Seizures
 C P Muscle weakness
 C P Pinched nerve
 C P Tremors
 C P Dizziness or vertigo
 C P Numbness or tingling in extremities

Head

C P Headache
 C P Migraines
 C P Head injury
 C P Jaw/TMJ problems

Ears

C P Ringing in ears/tinnitus
 C P Earaches
 C P Ear infection/fluid in ear
 C P Hearing loss

Eyes

C P Spots in eyes/floaters
 C P Cataracts
 C P Eye strain/pain
 C P Blurred vision
 C P Eye surgery
 C P Tearing or dry eyes
 C P Glasses/contacts
 C P Glaucoma
 C P Double vision
 C P Color blindness
 C P Macular degeneration or detached retina

Please check any health condition or symptom you have or have had:

Circle C for Current Condition and/or P for Past condition. Leave blank if you have never had the condition.

Mouth & Throat

- C P Trouble or pain with swallowing
- C P Teeth grinding
- C P Gum problems
- C P Excessive saliva
- C P Hoarseness/loss of voice
- C P Mouth/tongue sores
- C P Dry mouth/decreased saliva
- C P Tooth loss
- C P Clicking jaw
- C P Cavities, root canal - How many _____?

Gastrointestinal

- C P Heartburn
 - C P Appetite changes increase/decrease
 - C P Gas/Bloating
 - C P Ulcer
 - C P Abdominal pain/cramps
 - C P Colon polyps
 - C P Gallbladder problems/gallstones
 - C P Liver problems
 - C P Heartburn/Reflux
 - C P Constipation
 - C P Diarrhea
 - C P Nausea or vomiting
 - C P Belching
 - C P Vomiting blood
 - C P Blood in stool
 - C P Change in bowel movements
 - C P Black stools
 - C C Hemorrhoids/rectal fissures
- Do you have difficulty passing bowel movements?
Y N
- How often do you have a bowel movement? _____

Are your stools: liquid soft formed hard

Urinary

- C P Pain with urination
- C P Increased urinary frequency
- C P Increased urinary urgency
- C P Kidney stones
- C P Frequency at night
- C P Frequent infections

Blood/Peripheral Vascular

- C P Blood clots
- C P Phlebitis
- C P Easy bleeding/bruising
- C P Deep leg pain
- C P Varicose veins
- C P Swollen ankles
- C P Rheumatic fever
- C P Anemia
- C P Cold hands/feet
- C P Anti-clotting medication

Musculoskeletal

- C P Joint pain or stiffness
- C P Leg pain
- C P Muscle cramps or spasms
- C P Back pain
- C P Neck pain
- C P Back surgery
- C P Arthritis
- C P Muscle weakness
- C P Sciatica
- C P Car accident - how many _____?
- C P Spinal disc problems
- C P Osteoporosis
- C P Broken Bones

Mental/Emotional

- C P Mood Swings
- C P Considered/attempted suicide
- C P Trouble concentrating
- C P Depression
- C P Anxiety/Nervousness
- C P Memory problems

Men's Health

- C P Hernias
- C P Testicular masses
- C P Testicular or groin pain
- C P Prostate problems
- C P Discharge or sores
- C P Impotence/erectile dysfunction
- C P Premature ejaculation
- C P Sexually transmitted infection

Are you sexually active?

What form of birth control do you use?

Do you do self-testicular exam?

Do you wear a seat belt?

Please check any health condition or symptom you have or have had:

Circle C for Current Condition and/or P for Past condition. Leave blank if you have never had the condition.

Women's Health

- C P Irregular cycles
- C P Heavy bleeding
- C P Bleeding between cycles
- C P Premenstrual syndrome
- C P Cramping with menses
- C P Menopausal symptoms
- C P Breast lumps
- C P Abnormal PAP

Are you sexually active?

What form of birth control do you use?

Women's Health

- C P Endometriosis
- C P Ovarian cysts
- C P Uterine fibroids
- C P Painful intercourse
- C P Sexually transmitted infection
- C P Difficulty conceiving
- C P Hysterectomy
- C P Cervical dysplasia

Do you do self- breast exams?

Do you get regular mammograms?

Do you wear a seat belt?

Family Health History

Please mark any family members who have had these conditions: M = Mother, F = Father, S = Sister,

B = Brother, GM = Grandmother, GF = Grandfather, A = Aunt, U = Uncle, C = Cousin

Breast Cancer:	High Cholesterol:	Arthritis:
Colon Cancer:	Stroke:	Diabetes:
Ovarian Cancer:	Heart Disease:	Epilepsy:
Stomach or Liver Cancer:	High Blood pressure:	Mental Illness:
Anemia:	Thyroid problems:	Alcoholism:
Tuberculosis:	Allergies:	Asthma:
Alzheimer's Disease:	Depression:	Eczema:

What is your intention or what are your health goals in seeking treatment at this time?
