PREVENTIVE MEDICAL CENTER OF MARIN
PATIENT PERSONAL HEALTH HISTORY

Please Print

Date: ________________

I. GENERAL INFORMATION

Name:____ Phone: (___)________________________

Street Address: (mailing) ______________________________ Birth date: ______/_____/____________

City, State, Zip: ______________________________________ Birthplace: __________________________

Best Phone Contact: (___)____________________________ Email: ___________________________________

Work/Occupation: ____

What was your general health as a child? ____

Approximate date of last medical exam: ____/______/_______Where?____________________________

Are you presently under a doctor's care? __________ Name: ______________________________________

For what?: ____

Do you have any allergies to medicines, foods, or environmental exposures? ________________ _______

To what?____

What Rx or OTC Meds do you take? ____

____

What Natural Supplements? ____

____

Any other healers, helpers, or therapies with which you are involved?_______________________________

If yes, who and for what? ____

II. CURRENT FOCUS & PAST EVENTS

Why have you come to the Preventive Medical Center of Marin? ___________________________________

____

Were you referred? ___________________ If yes, by whom? ____________________________________

What is your primary concern? ____

____

List any other current symptoms or problems: ____

____

What are three factors in your life that seem the most important to your daily health?

____

____

Have you had any operations? __________ If so, what and when (year)? ___________________

____

Have you had any major injuries/accidents?: ___________ If so, what and when (year)? ____________

____

Have you had any major illnesses or been hospitalized for any reason? ____________________________

If so, what and when (year)? ____

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III. CHECKLIST FOR PRESENT OR ONGOING SYMPTOMS

Check any ailment/problem you currently have, or have had in the past two years.

Mark two checks if ailment occurs often; and three checks if it is a regular difficulty.

________weight gain	________sores in mouth	________urinary problems
________weight loss	________tongue problems	________bladder/kdny infctns
________fatigue	________coated tongue	________blood in urine
________confusion/fogginess	________bad breath	________back pains
________nervousness	________sore throats	________neck pains
________cold hands/feet	________teeth/gum problems	________muscle tension
________itching	________sinus congestion	________muscle cramps
________skin rashes	________cough	________leg swelling/edema
________hay fever	________difficulty breathing	________bone or joint pains
________skin boils	________shortness of breath	________joint swelling
________headaches	________coughing blood	________arm or leg problems
________fevers	________heart palpitations	________menstrual problems
________nightmares	________chest pains	________bruise easily
________insomnia	________breast lumps or pains	________irregular bowels
________dizziness	________gas or bloating	________number BMs/day
________blackouts	________abdominal pain	________bloody or black stools
________ringing in ears	________constipation	________increased sex desire
________earaches	________diarrhea	________decreased sex desire
________double/blurry vision	________difficult digestion	________aging rapidly
________nosebleeds	________hemorrhoids	________poor endurance
________sinus infections	________mucus problems	________low self-esteem

IV. PAST PROBLEMS

Please enter your age at the last occurrence of any that apply. If frequent enter “often.”

________ anemia	________ high blood pressure	________ kidney infection
________ allergies/hay fever	________ low blood pressure	________ kidney stone
________ asthma	________ heart disease	________ rheumatic fever
________ hives	________ stroke	________ irregular heart beats
________ hypoglycemia	________ heart attack	________ measles, German
________ diabetes	________ cancer	________ measles, regular
________ parasites	________ blood transfusion	________ mumps
________ epilepsy	________ migraine headache	________ chicken pox
________ eczema	________ ulcer	________ polio
________ skin boils	________ gout	________ whooping cough
________ skin rashes	________ arthritis	________ diphtheria
________ drug reaction	________ obesity	________ colitis
________ psoriasis	________ mental breakdown	________ syphilis
________ hepatitis	________ jaundice	________ gonorrhea
________ candida problems	________ mononucleosis	________ herpes
________ recurrent infections	________ chronic fatigue	________ infertility

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V. FAMILY HISTORY

List birthdates and health status of immediate family. Write A/W (for Alive and Well) or write in any chronic illness(es) they have. If deceased, mark D and indicate the cause and age at death. Check Sister or Brother and their health conditions if relevant. If you have many siblings, do a few.

Family Member	Birthdate	Health Status
Mother	______________	__________________________________
Father	______________	__________________________________
S (_) / B (_)	______________	__________________________________
S (_) / B (_)	______________	__________________________________
S (_) / B (_)	______________	__________________________________
S (_) / B (_)	______________	__________________________________

Do any of these illnesses run in your family? If so, please check and note above.

_______ diabetes | _______ asthma | _______ mental illness

_______ high blood pressure | _______ gout | _______ thyroid problems

_______ heart disease | _______ cancer | _______ obesity

_______ tuberculosis | _______ epilepsy | _______ twins (not illness)

LIST INFORMATION ON YOUR CHILDREN AND RELATIONSHIPS:

Children's Names:	M or F	Birthdate
__________________________	_______	______________________
__________________________	_______	______________________
__________________________	_______	______________________

Marriages and Significant Partners:	Dates	Status
__________________________	_______	______________________
__________________________	_______	______________________
__________________________	_______	______________________

VI. WOMEN & CYCLES

Date of last menstrual period? _________________ Are your periods regular? ________________

Age of your first menstrual period? _________ Problems in early years? __________________

How many days is your flow? __________________ Is it heavy? _______________________________

Do you have painful or symptomatic periods? __________ If so, please describe. ______________________

____

When was your last pap test? ___________ Ever an abnormal one? ______________________

Number of pregnancies: _________ Deliveries _______ Any problems? ____________________

Do you practice birth control? ___________ What form? ___________________________________

Have you used BC pills: ________________ How many years? _________________________

Have you had a mammogram? _______ When was the last? ___________ Normal? ________________

Do you practice breast self-exam? _____________ Ever had a breast biopsy? ____________ Normal? ___________

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VII. DIET AND EXERCISE

Do you have a good appetite? ___________________Good eating habits? ___________________________________

Do you crave any foods?______ Which foods? ____

How do you feel about the foods you eat?____

What several foods do you like and eat most often? ____

____

How are your teeth and gums? __________________ Do you chew your food well? ____________________

Do you brush and floss regularly and practice healthy hygiene? _____________________________________

Write the servings per day or week in your diet that make up these basic food categories.

For example, if you eat vegetables 3 times a day, write 3/D, or fish twice a week, write 2/W.

fruits___________________ grains/breads ________________ dairy products ___________________

vegetables _____________ nuts or seeds ________________ eggs __________________________

juices ________________ beans/legumes _______________ animal proteins ____________________

Animal Proteins (Total 100%) beef/lamb _____ poultry ________ fish __________lunchmeat_________________

Do you use many foods made with chemical additives or preservatives? ______________________________

If so, mainly what? ____

Percent of food you eat from restaurants?_______ Percent of home-prepared food? ____________________

For the next categories, estimate the number of times in a day or week you consume these items.

Examples: 0=Never, ___/w=number weekly, or ___/d=No. of times daily if utilized regularly

FOOD CATEGORIES/SUBSTANCES	**ALCOHOL/DRUGS**
Fried foods: ___________________________	Wine:_________________________________
White sugar or corn syrup: _______________	Beer: _________________________________
Food Additives: _________________________	Hard liquor: ____________________________
Soft drinks/ Sodas: ______________________	Rec. Drugs: ____________________________
Coffee: _______________________________	Nicotine: _______If "yes", how many years?_______

Is there one or more particular food flavors that you crave?

Check food flavors that you crave: sweet (__) spicy (__) bitter (__), sour (__) salty (__) other? ___________________

Do you have a garden?: __ Vegetable __________________ Flower ___________________________

Do you have any pets? What kind?: ____

EXERCISE

Do you enjoy exercise?: _________ Mild? ________________ Strenuous?___________________________

How often do you exercise weekly?: ____

How many hours a week do you typically exercise?____

Do you perspire/sweat easily?: ____

List exercise and frequency:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

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VIII. EMOTIONS, STRESS, ENERGY, AND PERSONAL

Are you able to express your emotions/feelings? ____________________

Is there any of these that you feel predominantly? If so, please check appropriate ones.

anger/frustration ________ sadness _____ fear __________ sympathy/worry _______

excessive joy __________ depression _____ anxiety/panic ___ other _________

Are you too emotional or too unemotional? ____________________

Would you consider any aspect of your childhood abusive? Please check.

emotionally _______ physically _______ sexually _______

What makes you nervous? ____________________

____

Is there much stress in your life? _________If so, what does it surround? i.e., family, work, finances, relationships, etc.

____

Do you have close friends, family and/or personal support:?____________________

How important are your animal friends to you? ____________________

ENERGY & SLEEP/PERSONAL:

Are you happy with your general energy level? ____________________

Is there a low point in your day? _______________ When? ____________________

What affects your energy level? ____________________

Are there climates you especially don't like? What and why? ____________________

Do you feel fatigued after you exercise? ____________________

Do you sleep well? __________________ How many hours a night? ____________________

Is your sleep interrupted? ________ Why do you think this is? ____________________

What is your favorite season? __________ Why? ____________________

With whom do you live? ____________________

What is your work? ____________________

Do you enjoy your career? _________What are your hobbies/pleasures? ____________________

____

How do you feel about yourself? ____________________

____

About your life? ____________________

____

Any questions you have for the doctor? ____________________

____

____

Do you have any special needs from the Preventive Medical Center?____________________

____

____

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