Health History and Adult Intake

Optimal health is only when there is a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this confidential overview will greatly assist in understanding your healthcare needs and desires.

Patient name: [Last]_____ [First]_____Date_____

Date of birth: _____ Age: _____ Male_____ Female_____

Phone: (Home)_____ (Work with extension) _____

Phone: (Mobile)_____ Email: _____

Emergency Contact: _____ Phone: _____

Occupation: _____ Employer:_____ Hrs./Week_____

Marital Status: Single____Married/Partnership___ Separated_____ Divorced___ Widowed_____

With whom do you live: Spouse_____ Family____ Friends____ Alone____ Children____

Do you have children? _____ #:_____

How were you referred to us? _____

What communication do you prefer: Cell_____ Work_____ E-mail_____

Leave message? Yes_____ No_____

What are your primary health goals? [List in order of importance]

1._____

2._____

3._____

4._____

5._____

How do you need assistance reaching your goals?

What obstacles are preventing you from achieving your goals?

Are you seeking primary care from Michelle Murphy? Yes_____ No_____

If No, who is your primary care physician? [Name]_____

Screening History:

Mammogram: Date_____Location_____Normal/Abnormal_____

Colonoscopy: Date_____ Location_____Recommended time to repeat_____

Prostate Exam: Date_____ Normal_____

Pap: Date_____Location_____Normal/Abnormal_____

Labs: Date_____ Location_____

General Information:

Height_____Weight_____ Weight 1yr ago_____ Maximum weight_____When_____

When during the day is your energy and alertness best?_____ Worst?_____

Primary interests and hobbies_____

Primary form of exercise, if any_____

How often?_____

Family History

Indicate if there have been any of the following diseases in you, your parents, brothers, sisters or children. Indicate the number of relatives who have the disease.

	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)	_____	_____	_____	_____	_____	_____
Health (G-good/ P-poor)	_____	_____	_____	_____	_____	_____
Check (X) those applicable						
Cancer	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____	_____	_____
High BP	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____

Mental Illness _____ _____ _____ _____ _____ _____

Asthma _____ _____ _____ _____ _____ _____

Hives/Hayfever_____ _____ _____ _____ _____ _____

Glaucoma _____ _____ _____ _____ _____ _____

Childhood Illness

Circle V if you had VACCINATION or Y if you had DISEASE

Measles	V	Y	Diphtheria	V	Y	German Measles	V	Y
Mumps	V	Y	Tetanus	V	Y	Scarlet Fever	V	Y
Polio	V	Y	Pertussis	V	Y	Rheumatic Fever	V	Y

Other:_____

Hospitalization and Surgery

What hospitalizations and surgeries have you had?

_____ year_____ _____ year_____

_____ year_____ _____ year_____

_____ year_____ _____ year_____

Medication and Supplements

List any prescription medications, over the counter medications, vitamins, or other supplements you are taking:

1._____ 2._____

3._____ 4._____

5._____ 6._____

7._____ 8._____

Check Each That You Currently Use

___Laxatives ___Pain relievers ___H2 Blockers/Ulcer meds ___Antacids ___Antibiotics

___Cortisone/Predisone ___Appetite suppressants ___Antidepressants ___Tranquilizers

___Thyroid medication ___Cholesterol-lowering medication ____Sleeping medication

___Other:_____

___Supplements:_____

Allergies

Are you hypersensitive or allergic to:

Any drugs?_____

Any foods?_____

Any enviromentals?_____

Any chemicals?_____

Typical Food Intake

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Do you strongly desire any particular foods_____

Do you strongly dislike any particular foods?_____

Are there any foods which make you feel bad or aggravate any of your symptoms?

_____

Lifestyle Habits

Answer the questions or check any of the following that apply:

___Average 6-8 hrs. of sleep

___Sleep well

___Awake rested

___Have a supportive relationship

___History of abuse

___Major traumas

___Used recreational drugs

___Treated for drug dependence

___Drink coffee

___Drink black or green tea

___Spend time outside

How much____

___Watch TV

How much___

___Read

How much___

___Drink alcohol beverages

per week_____

___Treated for alcoholism

___Use tobacco currently

___Drink cola or other soft drinks

___Use artificial sweeteners

___Enjoy your work

___Take vacations

___Used tobacco in the past

How many years_____

Packs per day_____

___Have a religious/spiritual practice

Review of Systems

Circle the response that applies:

Y: Condition you have NOW P: Condition you have had in the PAST N: Condition you have NEVER had

SKIN

Rashes	Y	P	N
Eczema	Y	P	N
Acne	Y	P	N
Itching	Y	P	N
Color change	Y	P	N
Hair loss	Y	P	N

HEAD

Headache	Y	P	N
Migraines	Y	P	N
Head injury	Y	P	N
Dandruff	Y	P	N

EARS

Impaired hearing	Y	P	N
Ringing/Noises	Y	P	N
Earache	Y	P	N
Dizziness	Y	P	N
Itching ears	Y	P	N

MOUTH, THROAT & NECK

Frequent sore throat	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Canker sores	Y	P	N
Swollen glands	Y	P	N
Goiter	Y	P	N

RESPIRATORY

Cough	Y	P	N
Spitting up mucus	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N

EYES

Impaired vision	Y	P	N
Glasses/Contacts	Y	P	N
Eye pain	Y	P	N
Redness	Y	P	N
Double vision	Y	P	N
Glaucoma	Y	P	N
Cataracts	Y	P	N
Aversion to sun	Y	P	N
Sites	Y	P	N

NOSE and SINUSES

Frequent colds	Y	P	N
Sinus problems	Y	P	N
Nose bleeds	Y	P	N
Stuffiness	Y	P	N
Loss of smell	Y	P	N
Frequent sneezing	Y	P	N
Hay fever	Y	P	N

URINARY

Pain on urination	Y	P	N
Increased frequency	Y	P	N
Frequency at night	Y	P	N
Inability to hold urine	Y	P	N
Frequent infections	Y	P	N
Kidney stones	Y	P	N

MALE PRODUCTIVITY

Hernias	Y	P	N
Testicular masses	Y	P	N
Testicular pain	Y	P	N
Are you sexually active		Y	N

Asthmas Y P N
Bronchitis Y P N
Pneumonia Y P N
Pleurisy Y P N
Emphysema Y P N
Difficulty breathing Y P N
Pain on breathing Y P N
Difficulty climbing stairs Y P N

CARDIOVASCULAR

Heart disease Y P N
Angina Y P N
High blood pressure Y P N
Murmurs Y P N
Rheumatic Fever Y P N
Chest pain Y P N
Swelling in ankles Y P N
Palpitations, fluttering Y P N

GASTROINTESTINAL

Trouble swallowing Y P N
Heartburn Y P N
Change in thirst Y P N
Change in appetite Y P N
Nausea Y P N
Vomiting Y P N
Constipation Y P N
Bloating Y P N
Bowel movements
How often? _____
Is this a change? Y N
Blood in stool Y P N
Diarrhea Y P N
Passing gas Y P N
Gall Bladder disease Y P N
Liver disease Y P N
Hemorrhoids Y P N
Abdominal pain Y P N
Ulcer Y P N

MUSCOSKELETAL

Joint pain or stiffness Y P N
Arthritis Y P N
Broken bones Y P N
Muscle spasms Y P N
Weakness Y P N

Sexual preference
__Heterosexual __Homosexual __Bisexual
Sexual difficulties Y P N
Prostate disease Y P N
STD's Y P N
Discharge or sores Y P N

FEMALE REPRODUCTIVE

Age menses began? _____
Average # od days bleeding? _____
Length of cycle?
[Day 1 bleeding to next day 1] _____
Are cycles irregular Y P N
Bleeding between cycle Y N
Painful menses Y P N
Excessive flow Y P N
PMS Y P N
Abnormal paps Y P N
Birth control Y N
What type? _____
# of pregnancies _____
# of live births _____
# of miscarriages _____
# of abortions _____
Difficulty conceiving Y N
Menopausal symptoms Y P N
Uterine fibroids Y P N
Endometriosis Y P N
Ovarian cysts Y P N
Sexually active? Y N
Sexual preference
__Heterosexual __Homosexual ___Bisexual
Sexual difficulties Y P N
Pain during intercourse Y P N
STD's Y P N
Do you do self-breast exams? Y N
Lumps Y P N
Pain or tenderness Y P N
Nipple discharge Y P N

ENDOCRINE

Hypo/Hyperthyroid Y P N
Heat/Cold Intolerance Y P N
Excessive Thirst Y P N
Excessive Hunger Y P N
Hypoglycemia Y P N

PERIPHERAL VASCULAR

Deep leg pain	Y	P	N
Cold Hands/Feet	Y	P	N
Varicose veins	Y	P	N
Thrombophlebitis	Y	P	N

NEUROLOGICAL

Seizures	Y	P	N
Paralysis	Y	P	N
Muscle weakness	Y	P	N
Numbness or tingling	Y	P	N
Loss of memory	Y	P	N
Loss of balance	Y	P	N

MENTAL/EMOTIONAL

Treated for emotional problems?	Y	P	N
Depression	Y	P	N
Considered/Attempted suicide?	Y	P	N
Increased irritability	Y	P	N
Mood swings	Y	P	N
Anxiety or nervousness	Y	P	N

Fatigue	Y	P	N
Diabetes	Y	P	N

BLOOD

Anemia	Y	P	N
Easy bleeding	Y	P	N
Bruising	Y	P	N
Blood clots	Y	P	N

SLEEP

Difficulty falling asleep	Y	P	N
Jerking on falling asleep	Y	P	N
Interrupted sleep	Y	P	N

Number of hours sleep/night _____

Feel rested in morning Y P N

Thank You!

We look forward to serving you and providing you with care. If you have and questions, please ask!

I certify that the information that I have supplied is correct and accurate to the best of my knowledge.

Name:_____

[Signature]

Date:_____

Consent To Treat

Patient's name:_____
[First] [Middle] [Last]

This is to acknowledge that I have been informed and understand that:

1. Any treatment or advice provided to me as a patient of Michelle Murphy is not mutually exclusive from any other treatment or advice that I may be receiving now or in the future, from another healthcare provider.

2. I am at liberty to seek or continue medical care from a physician, surgeon, or other healthcare provider.

3. No physician, healthcare provider, or staff member at the office of Michelle Murphy is recommending that I refrain from seeking or following the advice of another licensed healthcare provider.

4. Recommended therapies provided by this clinic may be from those usually offered by another licensed healthcare provider.

5. I hereby authorize and consent to treatment.

Name:_____ Date:_____