

Confidential Health History

Mark (c) for current problems, check and indicate the age when you had any of the following:

General

- Allergies
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Headaches
- Loss of sleep
- Mental illness
- Nervousness
- Tremors
- Weight loss / gain

Muscle / Joint

- Arthritis / rheumatism
- Bursitis
- Foot trouble
- Muscle weakness
- Low back pain
- Neck pain
- Mid back pain
- Joint pain

Skin

- Boils
- Bruise easily
- Dryness
- Hives or allergies
- Itching
- Rash
- Varicose veins

Eye, Ear, Nose & Throat

- Colds
- Deafness
- Ear ache
- Eye pain
- Gum trouble
- Hoarseness
- Nasal obstruction
- Nose bleeds
- Ringing of the ears
- Sinus infection
- Sore throat
- Tonsillitis
- Vision problems

Gastrointestinal

- Abdominal pain
- Bloody or tarry stool
- Colitis / Crohn's
- Colon trouble
- Constipation
- Diarrhea
- Difficult digestion
- Diverticulosis
- Bloating abdomen
- Excessive hunger
- Gallbladder trouble
- Hernia
- Hemorrhoids
- Intestinal worms
- Jaundice
- Liver trouble
- Nausea
- Painful defecation
- Pain over stomach
- Poor appetite
- Vomiting
- Vomiting of blood

Genitourinary

- Bed-wetting
- Bladder infection
- Blood in urine
- Kidney infection
- Kidney stones
- Prostate trouble
- Pus in urine
- Stress incontinence

Urination

- Overnight more than twice
- More than 8x in 24hrs
- Decreased flow/force
- Painful urination
- Urgency to urinate

Cardiovascular

- High blood pressure
- Low blood pressure
- Hardening of the arteries
- Irregular pulse
- Pain over heart
- Palpitation
- Poor circulation
- Rapid heart beat
- Slow heart beat
- Swelling of ankles

Respiratory

- Chest pain
- Chronic cough
- Difficulty breathing
- Hay fever
- Shortness of breath
- Spitting up phlegm / blood
- Wheezing

Women only

- Congested breasts
- Hot flashes
- Lumps in breast
- Menopause
- Vaginal discharge

Menstrual flow

- Reg. Irreg. Pain / cramps
 Days of flow: ____ Length of cycle: ____
 Date - 1st day last period: _____
 Are you pregnant? yes, no
 If yes, how many months? ____
 How many children do you have? ____
 Birth control method: _____
 Date of last PAP test: _____
 normal, abnormal
 Date of last mamogram: _____
 normal, abnormal

Check any of the conditions you have or have had:

- Alcoholism
- Anemia
- Appendicitis
- Arteriosclerosis
- Asthma
- Bronchitis
- Cancer
- Chicken pox
- Cold sores
- Diabetes
- Eczema
- Edema
- Emphysema
- Epilepsy
- Goiter
- Gout
- Heart burn
- Heart disease
- Hepatitis
- Herpes
- High cholesterol
- HIV/AIDS
- Influenza
- Malaria
- Measles
- Miscarriage
- Multiple sclerosis
- Mumps
- Numbness/tingling
- Pace maker
- Osteoporosis
- Pneumonia
- Polio
- Rheumatic fever
- Stroke
- Thyroid disease
- Tuberculosis
- Ulcers

Please list any medication you are currently taking and why:

Family history

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleed easily | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease |

Habits

- | | none | light | mod. | heavy |
|----------|--------------------------|--------------------------|--------------------------|--------------------------|
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coffee | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Drugs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Exercise | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

PATIENT NAME _____

DATE _____

CONSULTATION QUESTIONNAIRE

1. What is your major symptom? _____
2. When did you first notice your symptoms? _____
3. If this is a recurrence, when was the first time you noticed this problem? _____
How did it originally occur? _____
4. Has it been getting worse? Yes No Same Better Gradually Worse
If yes, when and how? _____
5. How frequent is the condition? Constant Daily Intermittent Night Only
How long does it last? All Day Few Hours Minutes
6. Describe the pain: Sharp Dull Numbness Tingling Aching Burning
 Stabbing Other _____
7. Does the pain radiate? Yes No
If yes, where does it radiate to? _____
8. What makes the problem worse? Standing Sitting Lying Bending Lifting
 Twisting Other _____
9. Is there anything you can do to relieve the problem? Yes No. If yes, describe _____
_____. If no, what have you tried to do that has not helped? _____

10. What does this prevent you from doing or enjoying? _____
11. Are there any other conditions or symptoms that may be related to your major symptom? Yes No
If yes, describe: _____
Are there other unrelated health problems? Yes No. If yes, describe _____

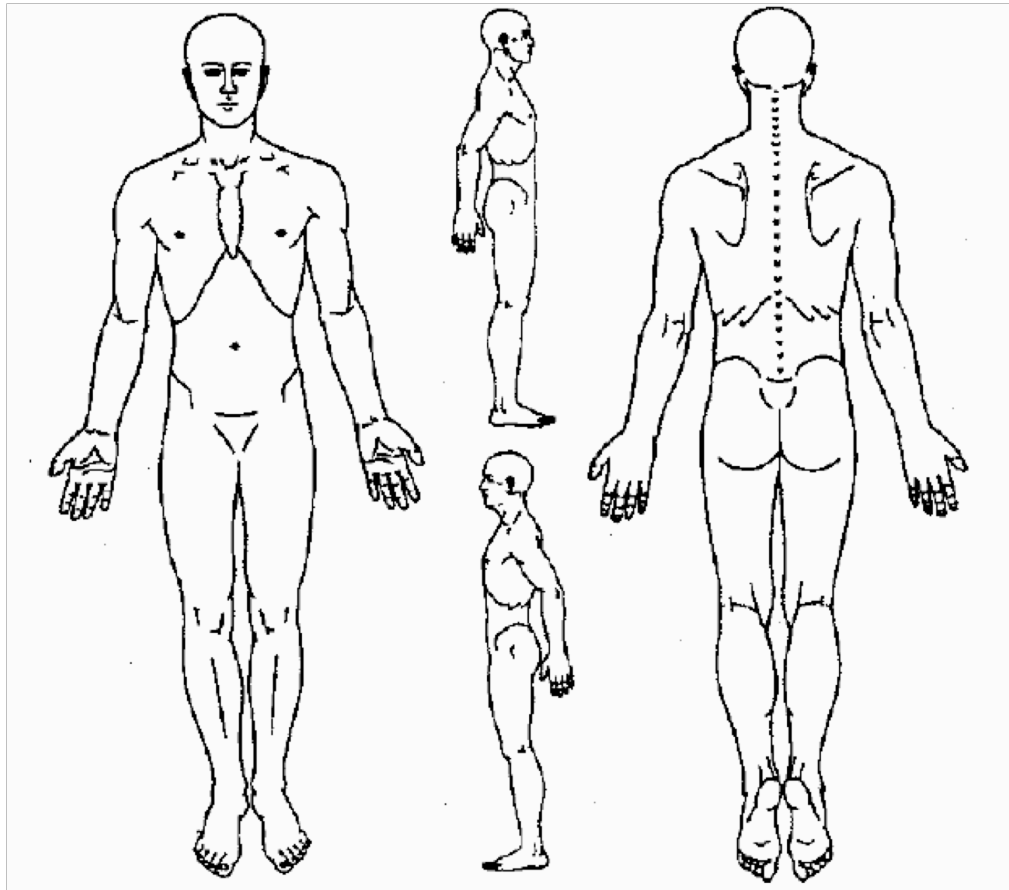
12. List any major accidents you have had other than those that might be mentioned above: _____

13. WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant?
 Yes No Uncertain
14. What else should Dr. Venuti know about your current condition? _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	○ ○ ○ ○ ○	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
-----	○ ○ ○ ○ ○	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
-----	○ ○ ○ ○ ○	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



NAME _____

DATE _____

No Pain |-----| Worst Possible Pain

Please make a slash through this line as to the level of your pain.

Patient Signature