Perlis Wellness Center

□**New** □**Update**

Medical History

Name _____ Date of Birth _____ Gender: □M □F Date _____ Height _____ Weight ____

Symptoms: (check any symptoms you are currently having, or have had recently)

- □ Weight gain or loss
- □ Chronic fatigue
- □ Persistent Fever
- □ Changes in Vision
- □ Cough
- □ Shortness of Breath
- □ Swollen glands
- □ Breast tenderness
- □ Breast lumps
- □ Nipple discharge
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Constipation
- □ Abdominal Pain
- □ Nighttime urination
- □ Blood in urine
- □ Frequent urination
- □ Bladder discomfort
- □ Urinary Tract Infections
- □ Leaking urine/dribbling
- □ Blood in stool
- □ Fecal incontinence
- □ Bloating
- □ Vaginal discharge
- □ Vaginal odor
- □ Vaginal itching
- □ Vaginal dryness
- □ Irregular periods
- □ Painful periods
- □ Painful intercourse
- □ Decreased sex drive
- □ Erectile Dysfunction/Weakness
- □ Anxiety
- □ Depression
- □ Irritable
- □ Mood changes
- □ Forgetfulness
- □ Difficulty concentrating
- □ Hot flashes
- □ Night sweats
- □ Genital sores
- □ Hair Loss/Thinning
- □ Facial hair growth (Women)
- □ Lower leg swelling
- □ Varicose veins
- □ Bruise/Bleed easily
- □ Joint tenderness
- □ Muscle Weakness
- □ Decreased Motivation
- □ Headaches/Migraines
- □ New skin lesions
- □ Acne
- □ Changes in moles
- □ Difficulty sleeping
- □ Frequent illnesses
- □ Seasonal allergies
- □ Environmental allergies
- □ Other_____
  _____

Medical History (Have you ever had the following? (check all that apply)

- □ Anemia
- □ Arthritis
- □ Auto Immune Disorder _____
- □ Blood Transfusion
- □ Cancer_____
- □ Clotting Disorder
- □ Depression
- □ DVT/PE
- □ Digestive Problems
- □ Endometriosis
- □ Epilepsy
- □ Erectile Dysfunction
- □ Fibroids-Uterus
- □ Frequent Bladder Infections
- □ Frequent UTI's
- □ Gall Stones
- □ GERD
- □ Genetic Disorder
- □ Headaches/Migraines
- □ Heart Disease
- □ High Blood Pressure
- □ High Cholesterol
- □ Infertility
- □ Irregular Vaginal Bleeding
- □ Irritable Bowel/Colon
- □ Kidney Disease/Stones
- □ Liver Disorder
- □ Lupus
- □ Osteopenia/Osteoporosis
- □ Ovarian Cyst
- □ Painful Periods
- □ Psychiatric Disorder
- □ STD_____
- □ Thyroid Disorder
- □ Vaginal Infections
- □ Other_____
  _____
  _____
  _____

Social History:

Current Occupation _____

Marital Status □Single □Engaged □Partnered □Married □Divorced □Widowed

Do you use tobacco? □NO □YES What form?_____ How much per day?_____

Do you drink alcohol? □NO □YES How much?_____ How often?_____

Do you use illegal drugs? □NO □YES What form(s)? _____ How much?_____ How often?_____

How Much Exercise Do You Get? □Sedentary □1-2 Times/Mo □1-2 Times/Wk □Nearly Every Day □Daily

Please summarize your eating habits: _____
_____

Family History: Are you adopted? □NO □YES (if biological relative history is unknown, skip this section)

NOTE: Family Member = immediate family, mother, father, grandmother, grandfather, aunt, uncle, daughter, son

Problem	Family Member	Age Onset	Problem	Family Member	Age Onset
Anemia			Heart Disease		
Blood Disorder			High Cholesterol		
Cancer - Breast			High Blood Pressure		
Cancer - Ovarian			Kidney Disease		
Cancer - Uterine			Psychiatric Disorder		
Cancer - Other			Stroke		
Depression			Thyroid Disorder		
Diabetes - Childhood Onset			Other _____		
Diabetes - Adult Onset			Other _____		

Patient Name: _____ DOB: _____

Surgical History: (list all surgeries, accidents, and hospitalizations)

Surgery/Procedure	Year	Surgery/Procedure	Year

Current Medication: (list all prescriptions and over the counter medications and supplements you take regularly)

Medication	Dose	Frequency (how often?)	Prescribing MD/Over Counter

Allergies: (list all drug, latex, food, environmental allergies and sensitivities and the reaction you have if exposed)

Allergic To:	Reaction	Allergic To:	Reaction

WOMEN ONLY

Gynecologic History:

Your Most Recent:	Date	Result	Your Most Recent	Date	Result
Physical Exam			Cholesterol Check		
General Blood Test			Bone Density Scan		
Pap Smear			Pelvic Ultrasound		
Mammogram			Specific Hormone Tests		
Colonoscopy					

Age of first menstruation _____
Menopause □NO □YES since age _____
First day of most recent menstrual period _____
How many days do your periods last? _____
How often do you get your period? _____
Do you bleed or spot between periods? □NO □YES
Do you have painful periods or cramps? □NO □YES
Are you sexually active? □NO □YES *with* □Male/□Female/□Both

Number of sexual partners in the last year? _____
Have you ever been pregnant? □NO □YES
How many children have you had? _____
Are they all living? □NO □YES
Have you ever had a miscarriage? □NO □YES
Have you ever had an abortion? □NO □YES
Have you ever had an ectopic pregnancy? □NO □YES, how many? _____
Do you have any adopted children? □NO □YES, how many? _____

Current Birth Control Method: (check all that apply)

□ Virgin	□ Natural Family	□ Condoms	□ IUD	□ Nuvaring	□ Tubal ligation
□ Abstinent	□ Planning	□ Foam/Gel	□ Pill	□ Depo-Provera	□ Hysterectomy
□ None	□ Withdrawal	□ Diaphragm	□ Patch	□ Vasectomy	□ No Male Partner

Obstetric History:

Date of Delivery, Miscarriage or Abortion	# of Weeks at Delivery	Sex of Baby	Type of Delivery (Vag or C-Section)	Complications	Location/Doctor

MEN ONLY

Your Most Recent:	Date	Result	Your Most Recent	Date	Result
Physical Exam			Cardiac Stress Test		
General Blood Test			Cholesterol Check		
PSA			Specific Hormone Tests		
Colonoscopy			Testosterone		

Are you sexually active? □NO □YES *with* □Male/□Female/□Both Number of sexual partners in the last year? _____Do you use safe sex practices? □NO □YES If YES, what form of protection do you use? _____

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