please print — This information will be contained in your confidential medical history

JULIE ANDERSON, ARNP, LLC HEALTH HISTORY

Name:	Birthdate:	Today's Date:

Main concern or reason (s) for visiting our clinic:

Please provide names and dates for the following:

Major Illnesses/Accidents	Hospitalizations/surgeries:

Have you ever experienced loss of consciousness due to a head injury? **Y N**

WELL BEING

Goals for Health:

What practices or activities do you use to sustain your health and well being?
(religious, spiritual, etc/what inspires you?)

Who do you turn to for support?	What causes stress for you?
Who lives in your home?	

NUTRITION/FOOD HABITS: Describe/summarize:____

____

MERCURY AMALGAM FILLINGS? **Y N** ROOT CANALS? **Y N** Date Removed:___________

SMOKING Packs/day__________ Number of years: ___________

Years stopped: ___________ Pipe? Chew? Cigar?

ALCOHOL Never Occasional Moderate Heavy

Alcohol Problem? **Y N** How much per week? ________

DRUG USE Use recreational drugs? **Y N** If yes, what type?________________________

CAFFEINE Coffee:______ per day Tea:______ per day Soda:______cans per month

EXERCISE Never Occasional Moderate Heavy

Height: ________Weight:________Weight at age 20:__________Weight change last year:___________

OCCUPATIONAL EXPOSURES: Asbestos? **Y N** Other___________________

Medications, Vitamins, Supplements - dose, frequency & start date

ALLERGIES:

DRUG ALLERGIES:

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System Review: Check if you have any symptoms or problem to any significant degree:

Date of last physical exam:

- ☐ Tired all the time
- ☐ Don't feel well
- ☐ Weakness
- ☐ Weight Problem
- ☐ Fluid Retention
- ☐ Lack of exercise

Date of last dental exam:

- ☐ Headache
- ☐ Migraine
- ☐ Fainting
- ☐ Dizziness
- ☐ Epilepsy/Seizure
- ☐ Ear/hearing prob.
- ☐ Ringing in ears
- ☐ Stuffy nose
- ☐ Nose bleeds
- ☐ Sinus Problem
- ☐ Hoarseness

Date of last eye exam:

- ☐ Glasses
- ☐ Vision/eye probs.
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Frequent Cough
- ☐ Cough Phlegm
- ☐ Cough Blood

- ☐ Freq. chest cold
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Short of breath
- ☐ Asthma/wheeze
- ☐ Hayfever
- ☐ Pleurisy
- ☐ Chest pain
- ☐ Heart trouble
- ☐ Heart murmur
- ☐ Heart palpitation
- ☐ Heart racing
- ☐ Chest tightness
- ☐ Chest pressure
- ☐ Angina
- ☐ Tire easily
- ☐ Enlarged heart
- ☐ Rheumatic fever
- ☐ Walking leg pain
- ☐ Varicose Veins
- ☐ Phlebitis
- ☐ Ankle swelling

Date of last chest X Ray:

Date of last EKG:

- ☐ Allergies
- ☐ Arthritis/joint pain

- ☐ Tr. swallowing
- ☐ Indigestion
- ☐ Heartburn
- ☐ Nervous stomach
- ☐ Ulcers
- ☐ Vomiting blood
- ☐ Black stools
- ☐ Bloody stools
- ☐ Rectal bleeding
- ☐ Abdominal pain
- ☐ Nervous colon
- ☐ Spastic colon
- ☐ Colitis
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowels
- ☐ Hemorrhoids
- ☐ Gall Bladder prob
- ☐ Yellow jaundice
- ☐ Liver disease
- ☐ Hernia
- ☐ Food intolerance
- ☐ Nervous
- ☐ Tense/Irritable
- ☐ Bored
- ☐ Depressed
- ☐ Trouble sleeping
- ☐ Relationship prob

- ☐ Job problems
- ☐ Personal problems
- ☐ Nervous breakdown
- ☐ Psychiatrist seen
- ☐ High blood sugar
- ☐ Hypoglycemia
- ☐ Thyroid trouble

Date of last bladder or urinary infection

- ☐ Bladder problems
- ☐ Kidney problems
- ☐ Kidney stone
- ☐ Difficulty with urine
- ☐ Sexually trans. disease
- ☐ Skin rash
- ☐ Skin trouble
- ☐ Allergy
- ☐ Food avoidance
- ☐ Bleed or bruise easily
- ☐ Anemia
- ☐ Blood disease
- ☐ Infertility problem
- ☐ Sexual difficulty

MEN ONLY

- ☐ Discharge from penis
- ☐ Prostate trouble
- ☐ Stream weak or slow
- ☐ Swelling or pain in testes

FAMILY HISTORY: (Check at left and list family members at right)
Diabetes
Heart Trouble
Heart Attack
High Blood Pressure
Stroke
Tuberculosis
Alcoholism/drinking problem
Cancer (kind?)
Autoimmune Disease
Arthritis (type?)
Other . . .

WOMEN ONLY:

Age menstruation began:_____ Periods: ____Regular ____Irregular Last menstuation:__________

Vaginal discharge? **Y N** Hot flashes? **Y N** Breast lump or discharge? **Y N**

# of miscarriages or abortions:_____ Type of birth control:______ IUD? **Y N** Year inserted:_____

Date of last mammogram:________Date of last pap smear____________

Pregnancies and outcomes (dates)____