PATIENT HISTORY

Patient Name: _____ DOB: _____

What would you like us to help you accomplish?

Please tell us any of your known medical problems or complaints.

(date of onset)
(date of onset)
(date of onset)
(date of onset)

Patient Name: _____ DOB: _____

Past Medical History: (please list any medical problems you had during these decades)

(birth to age 10)
(age 11 to age 20)
(age 21 to age 30)
(age 31 to 40)
(age 41 to 50)
(age 51 to 60)
(age 61 to 70)
(age 71 to 80)

Past Surgeries/Hospitalizations: What surgeries have you had or why were you hospitalized?

(date)
(date)
(date)
(date)
(date)

Patient Name: _____ DOB: _____

Current Prescription Medications: (please list all current medications)

Name	Dosage/Frequency	Comment

Current Non-Prescription Products: (laxatives, antacids, aspirin, vitamins, etc)

Name	Dosage/Frequency	Comment

Allergies to Medication: (name of drug, type of reaction)

Other Allergies or Sensitivities (chemicals, pollen, animals etc)

Patient Name: _____ DOB: _____

Family Medical History:

	Age if Alive	*or*	Age at Death	Significant Health Problems
Father				
Mother				
Brother/Sisters				
Children				

Family Illnesses: (have any family members including aunts or uncles developed any of the following?)

Please check all that apply:

	Heart attacks, coronary bypass, angioplasty, or angina over age 50
	Heart attacks, coronary bypass, angioplasty, or angina under age 50
	Strokes over age 50
	Strokes under age 50
	Other heart disease
	High blood pressure
	High cholesterol or triglycerides
	Diabetes
	Thyroid Disease
	Osteoporosis
	Obesity
	Colon Polyps
	Lung Disease
	Colon Cancer
	Breast Cancer
	Other Cancer
	Other

Patient Name: _____ DOB: _____

Social/Educational/Work History:

Where were you born? _____

Where do you currently live? _____

Marital Status: _____Single _____Married _____Divorced _____ Widow(ed)

Education: _____High School _____College _____Post Graduate _____Trade School/Prof Training

Current Work Status: What type of work do you do? How many hours/week?

_____

_____

Diet History:

How many times a day do you get hungry?_____

How many times a day do you eat?_____

How much do you currently weigh?_____

Why do you eat (boredom, stress, hunger)?_____

What is a typical day of eating like for you:

Meal 1 consists of: _____

_____

Meal 2 consists of: _____

_____

Meal 3 consists of: _____

_____

Meal 4 consists of: _____

_____

Beverage Intake: Coffee ? _____ Tea ? _____ Soft drinks? _____

Water ? _____ Other? _____

Patient Name: _____ DOB: _____

Exercise History:

How many times a week do you exercise? _____

What do you usually do? _____

Do you workout alone or with a trainer? _____

Do you workout at home or in a gym/facility? _____

Do you perspire? _____ Do you feel good afterward? _____

Sleep History:

Average number of sleep hours per night: _____

Usual bedtime: _____

Do you have difficulty falling asleep? Yes _____ No _____

Usual wake time: _____

How do you feel upon awakening? Tired ☐ Groggy ☐ Rested ☐

Do awake during the night? Yes ☐ No ☐

Do you awake to void? Yes ☐ No ☐

Do you have problems falling back to sleep? Yes ☐ No ☐

Do you use sleep medications? Yes ☐ No ☐

Do you have dreams? Yes ☐ No ☐

Do you grind your teeth/clench your jaw? Yes ☐ No ☐

Do you snore? Yes ☐ No ☐

Other problems? _____

Stress History:

On a scale of 1-10 (10 being the most) on what level do you live your life? _____

What areas contribute to stress?
Work Family Other relationships Health Concerns Money Self generated

What do you do to relax? _____

When you feel stressed do you hold it in or talk about it? _____

How many good friends do you have? _____

Patient Name: _____ DOB: _____

Stress History: cont'd

With how many people could you share or discuss intimate feelings? _____

Do you do any relaxation activities/hobbies? _____

Explain:_____

_____

_____

Do you practice relaxation/ stress reduction techniques? _____ How often? _____

Do you prefer to spend most of your time: with others _____ Alone _____

Do you manage your stress by: eating _____drinking _____ substance _____

Medical Team Information

In order to help Dr. Renna formulate a complete picture of your medical history please provide us with contact information for your current group of medical professionals or those physicians related to any medical problems or procedures you have had in the past (internists, dentists, surgeons, specialists, etc). If we did not provide you will enough room please continue the list of your medical team on another sheet of paper and include it with your paperwork. **None of these physicians will be contacted without your permission.**

Doctor's Name:_____Specialty:_____

Address:_____Phone:_____

City:_____ State:_____ Zip Code_____

Doctor's Name:_____Specialty:_____

Address:_____Phone:_____

City:_____ State:_____ Zip Code_____

Doctor's Name:_____Specialty:_____

Address:_____Phone:_____

City:_____ State:_____ Zip Code_____