Dr. Anne Marie Palzer

Personal Health History and Intake Form

Date:_____

Patient Name:_____ Date of Birth:_____ Age:_____

Chief Health Concern:_____

Past Medical Hisotry:

Have you ever had the following?: (*Circle "N" for No or "Y" for Yes. If uncertain leave blank.)*

Measles	Y N	Anemia	Y N	Back Trouble	Y N	Hepatitis	Y N
Mumps	Y N	Bladder Infections	Y N	High Blood Pressure	Y N	Ulcer	Y N
Chickenpox	Y N	Epilepsy	Y N	Low Blood Pressure	Y N	Kidney Disease	Y N
Whooping Cough	Y N	Migraines	Y N	Hives or Eczema	Y N	Thyroid Disease	Y N
Scarlet Fever	Y N	Tuberculosis	Y N	AIDS or HIV+	Y N	Diphtheria	Y N
Smallpox	Y N	Diabetes	Y N	Infectious Mono	Y N	Pneumonia	Y N
Rheumatic fever	Y N	Cancer	Y N	Bronchitis	Y N	Heart Disease	Y N
Arthritis	Y N	Polio	Y N	Mitral Valve Dz	Y N	Glaucoma	Y N
Venereal Disease	Y N	Hernia	Y N	Stroke	Y N	Blood transfusion	Y N

Any other disease? Please list._____

_____

Previous Hospitlizations/Surgeries?Serious Illnesses:_____

_____

_____

Medications and Supplements_____

_____

Patient Social History:

Marital Status: Single___ Married___ Separated___ Divorced___ Widowed___ Partnership___ Other___

Use of Alcohol: Never___ Rarely___ Moderate___ Daily___

Use of Tobacco: Never___ Previously, but quit___ Current packs/day___

Use of Caffeine: Never___ Soda___ Tea___ Coffee___ Chocolate___

Use of Drugs: Never___ Type/Frequency_____

Exposure at home or work to: Fumes___ Dust___ Solvents___ Air-borne Particles___ Noise___

Family Medical History

	Age	Disease	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Review of Systems:

CONSTITUTIONAL SYMPTOMS
Good general health lately Y N
Recent Weight Change Y N
Fever Y N
Fatigue Y N

EYES
Eye Disease/Injury Y N
Wear glasses/contacts Y N
Blurred/Double Vision Y N

EARS/NOSE/MOUTH/THROAT
Hearing loss or ringing Y N
Earaches/Drainage Y N
Chronic sinusitis Y N
Nose Bleeds Y N
Mouth Sores Y N
Bleeding Gums Y N
Bad Breath Y N
Sore Throat/Voice Change Y N
Swollen Neck Glands Y N
Difficulty Swallowing Y N

CARDIOVASCUALR
Heart Trouble Y N
Chest pain/Angina Y N
Palpitation (flutters) Y N
Shortness of Breath Y N
Walking or Laying Down
Swelling of feet/ankles/hand Y N
High Blood Pressure Y N
Chronic Frequent Cough Y N
Cough with Blood Y N
TB exposure Y N
Wheezing Y N
Asthma Y N
Last Chest X-ray_____

MUSCULOSKELETAL
Joint Pain Y N
Join Stiffness or Swelling Y N
Weakness of Muscle or Joint Y N
Muscle Pain or Cramps Y N
Back Pain Y N
Cold Extremities Y N
Difficulty Walking Y N

GENITOURINARY
Frequent Urination Y N
Burn/Painful Urination Y N
Blood in Urine Y N
Change in habits Y N
Incontinence Y N
Kidney stones Y N
Sexual difficulty Y N
Male: testicle pain Y N
Female: Painful periods Y N
Female: Irregular periods Y N
Female:# of pregnancies ____
Female: # miscarriages_____
Female: Last pap smear_____
Sexually active Y N
Birth Control_____

INTEGUMENTARY
(Skin/Breast)
Rash/Itching Y N
Change Hair/Nails Y N
Change in Skin Color Y N
Varicose Veins Y N
Breast pain Y N
Breast lump Y N
Breast Discharge Y N

PSYCIATRIC
Memory Loss/Confusion Y N
Nervousness/Anxiety Y N
Depression Y N
Insomnia Y N

HEMATOLOGIC/LYMPHATIC
Enlarged Glands Y N
Slow to Heal Cuts Y N
Bleeding/Easy Bruising Y N
Anemia Y N
Phlebitis/Blood Clots Y N
Inflammation of Veins Y N
Past Transfusion Y N

ENDOCRINE
Gland/Hormone problem Y N
Excessive Thirst/Urination
Y N
Heat Cold Intolerance Y N
Skin Dryness Y N

ALLERGIC
Penicillin/Other Antibiotics Y N
Morphine/Demerol Y N
Other Narcotics Y N
Novocain/Anesthetic Y N
Tetanus antitoxin/other serums Y N
Other Drugs/Medications Y N
Known Allergies/Food/Environment
_____
_____

GASTROINTESTINAL
Loss of appetite Y N
Change in bowel habits Y N
Nausea or Vomiting Y N
Frequent Diarrhea Y N
Painful bowel movement Y N
Constipation Y N
Abdominal Pain Y N
Rectal Bleeding Y N
Blood in Stool Y N
Hemorrhoids Y N

NEUROLOGICAL
Frequent recurring headaches Y N
Lightheaded or Dizzy Y N
Convulsions/Seizures Y N
Numbness or Tingling Y N
Tremors (shaking) Y N
Paralysis Y N
Head Injury Y N
Difficulty Walking Y N

IMMUNIZATIONS
Polio Y N
Flu Y N
Tetanus Y N
Date of Last Tetanus_____
Hepatitis B Y N
Diphtheria Y N
Pertussis Y N
Rubella Y N
Measles/Mumps Y N
Influenza Y N
Other Y N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I need.

_____ _____
Signature (parent or guardian if patient is under age 18) Date