PREVENTIVE MEDICAL CENTER OF MARIN
PATIENT PERSONAL HEALTH HISTORY

Please Print

Date: ________________

I. GENERAL INFORMATION

Name: ______________________________ Phone: (___) ______________

Street Address: (mailing) ______________________ Birth date: ____/____/________

City, State, Zip: ______________________ Birthplace: ______________

Cell Phone or Best Number: ______________________________

Work/Occupation: ______________________________

What was your general health as a child? ______________________________

Approximate date of last medical exam: ____/______/_______ Where? ______________

Are you presently under a doctor's care? __________ Name: ______________

For what?: ______________________________

Do you have any allergies to medicines, foods, or environmental exposures? ______________ ________

To what? ______________________________

What Rx or OTC Meds do you take? ______________________________

____

What Natural Supplements? ______________________________

____

Any other healers, helpers, or therapies with which you are involved? ______________

If yes, who and for what? ______________________________

II. CURRENT FOCUS & PAST EVENTS

Why have you come to the Preventive Medical Center of Marin? ______________

____

Were you referred? ______________ If yes, by whom? ______________

What is your primary concern? ______________________________

____

List any other current symptoms or problems: ______________________________

____

What are three factors in your life that seem the most important to your daily health?

____

____

Have you had any operations? __________ If so, what and when (year)? ______________

____

Have you had any major injuries/accidents?: __________ If so, what and when (year)? ______________

____

Have you had any major illnesses or been hospitalized for any reason? ______________

If so, what and when (year)? ______________________________

© 2010 Elson M Haas, MD

PREVENTIVE MEDICAL CENTER OF MARIN
PATIENT PERSONAL HEALTH HISTORY
Please Print

III. CHECKLIST FOR PRESENT OR ONGOING SYMPTOMS

Check any ailment/problem you currently have, or have had in the past two years.

Mark two checks if ailment occurs often; and three checks if it is a regular difficulty.

________weight gain
________weight loss
________fatigue
________confusion/fogginess
________nervousness
________cold hands/feet
________itching
________skin rashes
________hay fever
________skin boils
________headaches
________fevers
________nightmares
________insomnia
________dizziness
________blackouts
________ringing in ears
________earaches
________double/blurry vision
________nosebleeds
________sinus infections

________sores in mouth
________tongue problems
________coated tongue
________bad breath
________sore throats
________teeth/gum problems
________sinus congestion
________cough
________difficulty breathing
________shortness of breath
________coughing blood
________heart palpitations
________chest pains
________breast lumps or pains
________gas or bloating
________abdominal pain
________constipation
________diarrhea
________difficult digestion
________hemorrhoids
________mucus problems

________urinary problems
________bladder/kdny infctns
________blood in urine
________back pains
________neck pains
________muscle tension
________muscle cramps
________leg swelling/edema
________bone or joint pains
________joint swelling
________arm or leg problems
________menstrual problems
________bruise easily
________irregular bowels
________number BMs/day
________bloody or black stools
________increased sex desire
________decreased sex desire
________aging rapidly
________poor endurance
________low self-esteem

IV. PAST PROBLEMS

Please check any ailment you may have had. Indicate approximate year of occurrence.

________ anemia
________ allergies/hay fever
________ asthma
________ hives
________ hypoglycemia
________ diabetes
________ parasites
________ epilepsy
________ eczema
________ skin boils
________ skin rashes
________ drug reaction
________ psoriasis
________ hepatitis
________ candida problems
________ recurrent infections

________ high blood pressure
________ low blood pressure
________ heart disease
________ stroke
________ heart attack
________ cancer
________ blood transfusion
________ migraine headache
________ ulcer
________ gout
________ arthritis
________ obesity
________ mental breakdown
________ jaundice
________ mononucleosis
________ chronic fatigue

________ kidney infection
________ kidney stone
________ rheumatic fever
________ irregular heart beats
________ measles, German
________ measles, regular
________ mumps
________ chicken pox
________ polio
________ whooping cough
________ diphtheria
________ colitis
________ syphilis
________ gonorrhea
________ herpes
________ infertility

© 2010 Elson M Haas, MD

PREVENTIVE MEDICAL CENTER OF MARIN
PATIENT PERSONAL HEALTH HISTORY

Please Print

V. FAMILY HISTORY

List birthdates and health status of immediate family. Write A/W (for alive and well), or write in any chronic illness(es) they have. If deceased, mark D and indicate the cause. Circle Brother or Sister.

Family Member		Birthdate	Health Status
Mother		_______________	_____________________________________
Father		_______________	_____________________________________
Sister(s) or Brother(s)	S/B	_______________	_____________________________________
NOTE:	S/B	_______________	_____________________________________
Circle S for sister	S/B	_______________	_____________________________________
and B for brother	S/B	_______________	_____________________________________

Do any of these illnesses run in your family? If so, please check and note above.

________ diabetes	________ asthma	________ mental illness
________ high blood pressure	________ gout	________ thyroid problems
________ heart disease	________ cancer	________ obesity
________ tuberculosis	________ epilepsy	________ twins (not illness)

LIST INFORMATION ON YOUR CHILDREN AND RELATIONSHIPS:

Children's Names:	M or F	Birthdate
_____________________________________	________	______________________________
_____________________________________	________	______________________________
_____________________________________	________	______________________________

Marriages and Significant Partners:	Dates	Status
_____________________________________	________	______________________________
_____________________________________	________	______________________________
_____________________________________	________	______________________________

VI. WOMEN & CYCLES

Date of last menstrual period? ___________________ Are your periods regular? __________________

Age of your first menstrual period? __________ Problems in early years? ____________________

How many days is your flow? ____________________ Is it heavy? ____________________________________

Do you have painful or symptomatic periods? __________ If so, please describe. _______________________

____

When was your last pap test? ____________ Ever an abnormal one? ________________________

Number of pregnancies: __________ Deliveries _______ Any problems? ______________________

Do you practice birth control? ____________ What form? ______________________________________

Have you used BC pills: _________________ How many years? __________________________

Have you had a mammogram? ________ When was the last? ____________ Normal? _________________

Do you practice breast self-exam? _____________ Ever has breast biopsy? ____________ Normal? ___________

© 2010 Elson M Haas, MD

Please Print

VII. DIET AND EXERCISE

Do you have a good appetite? __________________ Good eating habits? __________________

Do you crave any foods? ______ Which foods? __________________

How do you feel about the foods you eat? __________________

What several foods do you like and eat most often? __________________

____

How are your teeth and gums? __________________ Do you chew your food well? __________________

Do you brush and floss regularly and practice healthy hygiene? __________________

Write the servings per day or week in your diet that make up these basic food categories.

For example, if you eat vegetables 3 times a day, write 3/D, or fish twice a week, write 2/W.

fruits __________________ grains/breads ________________ dairy products __________________

vegetables _____________ nuts or seeds ________________ eggs __________________

juices ________________ beans/legumes _______________ animal proteins __________________

Animal Proteins (Total 100%) beef/lamb _____ poultry ________ fish _________ lunchmeat __________________

Do you use many foods made with chemical additives or preservatives? __________________

If so, mainly what? __________________

Percent of food you eat from restaurants? ________ Percent of home-prepared food? __________________

For the next categories, estimate the number of times in a day or week you consume these items.

Examples: 0=Never, ___/w=number weekly, or ___/d=No. of times daily if utilized regularly

FOOD CATEGORIES/SUBSTANCES

Fried foods: __________________

White sugar or corn syrup: __________________

Food Additives: __________________

Soft drinks/ Sodas: __________________

Coffee: __________________

ALCOHOL/DRUGS

Wine: __________________

Beer: __________________

Hard liquor: __________________

Rec. Drugs: __________________

Nicotine: ________ If "yes", how many years? ________

Is there one or more particular food flavors that you crave?

Circle as many as apply: sweet, spicy, bitter, sour, salty, other? __________________

Do you have a garden?: __ Vegetable __________________ Flower __________________

Do you have any pets? What kind?: __________________

EXERCISE

Do you enjoy exercise?: _________ Mild? ________________ Strenuous? __________________

How often do you exercise weekly?: __________________

How many hours a week do you typically exercise? __________________

Do you perspire/sweat easily?: __________________

List exercise and frequency:

__________________ __________________

__________________ __________________

 © 2010 Elson M Haas, MD

PREVENTIVE MEDICAL CENTER OF MARIN
PATIENT PERSONAL HEALTH HISTORY
Please Print

VIII. EMOTIONS, STRESS, ENERGY, AND PERSONAL

Are you able to express your emotions/feelings? ______________________________

Is there any of these that you feel predominantly? If so, please check appropriate ones.

anger/frustration ________ sadness ______ fear __________ sympathy/worry ________

excessive joy __________ depression ______ anxiety/panic ____ other __________

Are you too emotional or too unemotional? ______________________________

Would you consider any aspect of your childhood abusive? Please check.

_______ emotionally _______ physically _______ sexually

What makes you nervous? ______________________________

____

Is there much stress in your life? _________If so, what does it surround? i.e., family, work, finances, relationships, etc.

____

Do you have close friends, family and/or personal support:?______________________________

How important are your animal friends to you? ______________________________

ENERGY & SLEEP/PERSONAL:

Are you happy with your general energy level? ______________________________

Is there a low point in your day? ______________ When? ______________________________

What affects your energy level? ______________________________

Are there climates you especially don't like? What and why? ______________________________

Do you feel fatigued after you exercise? ______________________________

Do you sleep well? ____________________ How many hours a night? ______________________________

Is your sleep interrupted? ________ Why do you think this is? ______________________________

What is your favorite season? __________ Why? ______________________________

With whom do you live? ______________________________

What is your work? ______________________________

Do you enjoy your career? _________What are your hobbies/pleasures? ______________________________

____

How do you feel about yourself? ______________________________

____

About your life? ______________________________

____

Any questions you have for the doctor? ______________________________

____

____

Do you have any special needs from the Preventive Medical Center?______________________________

____

____

© 2010 Elson M Haas, MD