

Welcome to our office at Cabeca Health!

Please fill out your medical history as completely as possible so we may better take care of you.

Patient's first name		Middle name		Last name		Soc. Sec. Number - -			
Street address (not Post Office Box)			City		State		Zip Code		
Date of Birth MM/DD/YYYY		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow(er) <input type="checkbox"/> Divorced <input type="checkbox"/> Partnered <input type="checkbox"/> Separated		Phone #: Home #: Cell #:		May we leave a message? Y/N Work#:	
Name of place where patient is employed:					Name of spouse/significant other:				
Occupation:					Spouse/S.O place of work/occupation:				

Tell us about your current medical care

Name of your current primary care physician:		May we contact? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Name of other health care providers you see:		May we contact? <input type="checkbox"/> No <input type="checkbox"/> Yes	

Tell us your thoughts about your current health situation

What is your primary reason for consulting with us?

What other concerns do you have?

When was the last time you felt great?

What medicines and other are you allergic to?

List all Medication/Supplement Names	Strength	#Times per day	When began	Reason for taking

Tell us about any medications you took in the past more than six months

<input type="checkbox"/> Antibiotics	<input type="checkbox"/> Birth Control Pills	<input type="checkbox"/> Statins (Cholesterol Lowering)	<input type="checkbox"/> Steroids
<input type="checkbox"/> Beta Blockers	<input type="checkbox"/> Diuretics	<input type="checkbox"/> Stomach Acid Reducers	<input type="checkbox"/> Other

Tell us about your most recent tests

Test	year	Test	year	Test	year	Test	year
<input type="checkbox"/> Breast Exam		<input type="checkbox"/> DEXA (Bone scan)		<input type="checkbox"/> Pap		<input type="checkbox"/> PSA	
<input type="checkbox"/> CA-125		<input type="checkbox"/> EKG		<input type="checkbox"/> Stool check for blood		<input type="checkbox"/> Vitamin D	
<input type="checkbox"/> Chest X-ray		<input type="checkbox"/> Glucose		<input type="checkbox"/> Other		<input type="checkbox"/> Other	
<input type="checkbox"/> Cholesterol		<input type="checkbox"/> HgbA1C		<input type="checkbox"/> Other		<input type="checkbox"/> Other	
<input type="checkbox"/> Colonoscopy		<input type="checkbox"/> Homocysteine		<input type="checkbox"/> Other		<input type="checkbox"/> Other	
<input type="checkbox"/> C-reactive protein		<input type="checkbox"/> Mammogram		<input type="checkbox"/> Other		<input type="checkbox"/> Other	

Please circle if you have any of the following

GEN Fever, chills, wt loss/gain, fatigue, muscle aches	Endo hot flashes, changes in sleep patterns, hair loss
EYES Glasses, glaucoma, cataracts, blurred vision	Breast tenderness, cysts, lump, discharge from nipple
ENT Hearing loss, sinus trouble, sore throats	GI SX abdominal pain, nausea, vomiting, constipation, diarrhea
HEME Anemia, bleeding problems, blood thinners	REN/GU burning with urination, bloody urine, loss of urine with urge to cough/sneeze, waking up at night to urinate
CARD Palpitations, chest pain, murmur	GYN vaginal discharge, cramps, heavy periods, midcycle spotting
RESP Shortness of breath, wheezing, cough	♀♂ decreased sex drive, problem with orgasm, pain w/ sex, decreased muscle strength, difficulty with erection
PSYCH Dizziness, tremors, headaches, loss of enjoyment in usual activities	

Please tell us about your social history

How much?

Do you smoke cigarettes? <input type="checkbox"/> yes <input type="checkbox"/> no	Are you sexually active? <input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever smoked cigarettes? <input type="checkbox"/> yes <input type="checkbox"/> no	Who lives at home?
How many years?	Are your immunizations current? <input type="checkbox"/> yes <input type="checkbox"/> no
Do you drink alcoholic beverages? <input type="checkbox"/> yes <input type="checkbox"/> no	Are you under any stress? <input type="checkbox"/> yes <input type="checkbox"/> no
Do you drink caffeinated beverages? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you exercise regularly? <input type="checkbox"/> yes <input type="checkbox"/> no
Do you use drugs? <input type="checkbox"/> yes <input type="checkbox"/> no	

Patient's first name	Middle name	Last name	Last 4 digits Soc. Sec. Number XXX-XX-
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Tell us about your personal medical history. If you have ever had any of the following please \checkmark , enter date and comment if appropriate

Disease/Illness	Date and comment	Disease/Illness	Date and comment
<input type="checkbox"/> Abnormal EKG		<input type="checkbox"/> Hiatal Hernia	
<input type="checkbox"/> Abnormal chest X-ray		<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Alcoholism		<input type="checkbox"/> High cholesterol	
<input type="checkbox"/> Allergies		<input type="checkbox"/> High homocysteine or high CRP level	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Incontinence	
<input type="checkbox"/> Angina pectoris		<input type="checkbox"/> Irritable bowel syndrome	
<input type="checkbox"/> Angioplasty or stent		<input type="checkbox"/> Jaundice	
<input type="checkbox"/> Anxiety or depression		<input type="checkbox"/> Kidney stones	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Liver disease	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Lupus	
<input type="checkbox"/> Autoimmune disorder		<input type="checkbox"/> Lyme Disease	
<input type="checkbox"/> Back problems		<input type="checkbox"/> Measles (Red - rubeola) (German – rubella)	
<input type="checkbox"/> Birth Defects		<input type="checkbox"/> Multiple Sclerosis	
<input type="checkbox"/> Bladder problems		<input type="checkbox"/> Mumps	
<input type="checkbox"/> Blood in urine		<input type="checkbox"/> Muscle or nerve disease	
<input type="checkbox"/> Blood clots		<input type="checkbox"/> Osteoarthritis	
<input type="checkbox"/> Blood transfusion		<input type="checkbox"/> Osteoporosis	
Blood Type: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> O <input type="checkbox"/> Don't know		<input type="checkbox"/> Ovarian cysts	
<input type="checkbox"/> Bowel Problems		<input type="checkbox"/> Paralysis, any body part	
<input type="checkbox"/> Breast Problems		<input type="checkbox"/> Pneumonia	
<input type="checkbox"/> Bronchitis		<input type="checkbox"/> Phlebitis	
<input type="checkbox"/> Cancer of the Breast, Ovaries, Colon, Prostate, Cervix, Skin, other What kind?		<input type="checkbox"/> Pinched nerves	
<input type="checkbox"/> Carotid artery disease		<input type="checkbox"/> Prostate problems	
<input type="checkbox"/> Carpal tunnel syndrome		<input type="checkbox"/> Psychiatric illness	
<input type="checkbox"/> Cataracts		<input type="checkbox"/> Raynaud's Syndrome	
<input type="checkbox"/> Chest pain		<input type="checkbox"/> Retinal detachment	
<input type="checkbox"/> Colitis or bowel spasm		<input type="checkbox"/> Retinal hemorrhage	
<input type="checkbox"/> Colon polyps		<input type="checkbox"/> Rheumatoid arthritis	
<input type="checkbox"/> Crohn's Disease		<input type="checkbox"/> Sarcoidosis	
<input type="checkbox"/> Diabetes Type I Type II		<input type="checkbox"/> Scarlet Fever	
<input type="checkbox"/> Diverticulosis		<input type="checkbox"/> Sciatica	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Seizures or convulsions	
<input type="checkbox"/> Environmental allergies		<input type="checkbox"/> Sensitivity to chemicals	
<input type="checkbox"/> Endometriosis		<input type="checkbox"/> Sensitivity to medications/drugs	
<input type="checkbox"/> Esophagitis (GERD)		<input type="checkbox"/> Serious back or neck injury	
<input type="checkbox"/> Fibromyalgia		<input type="checkbox"/> Serious broken bones	
<input type="checkbox"/> Gallbladder		<input type="checkbox"/> Serious head injury	
<input type="checkbox"/> Gallstones		<input type="checkbox"/> STD's <input type="checkbox"/> gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Trichomonas <input type="checkbox"/> PID	
<input type="checkbox"/> Glaucoma		<input type="checkbox"/> Syphilis <input type="checkbox"/> genital herpes <input type="checkbox"/> Herpes <input type="checkbox"/> Genital Warts	
<input type="checkbox"/> Gout		<input type="checkbox"/> Skin problems	
<input type="checkbox"/> HIV/AIDS		<input type="checkbox"/> Mitral valve prolapse	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Sinus problems	
<input type="checkbox"/> Headache/Migraines		<input type="checkbox"/> Stomach disorder	
<input type="checkbox"/> Heart attack		<input type="checkbox"/> Stroke or Transient ischemic attack	
<input type="checkbox"/> Heart disease		<input type="checkbox"/> Substance abuse	
<input type="checkbox"/> Heart Murmur		<input type="checkbox"/> Testicular or Penile problems or Impotence	
<input type="checkbox"/> Heavy metal toxicity		<input type="checkbox"/> Thyroid disease	
<input type="checkbox"/> Hemophilia		<input type="checkbox"/> Tuberculosis (T.B.)	
<input type="checkbox"/> Hemorrhoids		<input type="checkbox"/> Ulcerative colitis	
<input type="checkbox"/> Hepatitis		<input type="checkbox"/> Ulcers	
<input type="checkbox"/> Hereditary defects		<input type="checkbox"/> Urinary tract infections	
<input type="checkbox"/> Herpes or cold sores		<input type="checkbox"/> Uterine fibroids	
<input type="checkbox"/> Other:		<input type="checkbox"/> Varicose veins	
		<input type="checkbox"/> Yeast infections/Candida	

Tell us about your birth and early years

Were there complications at the time of your birth? No Yes (*describe*)

What was your weight at birth? _____ pounds _____ ounces Were you breast fed? No Yes

Were you a colicky baby? No Yes (*describe*)

Did you have health problems that you "outgrew"? No Yes (*describe*)

