BioHarmony medical

New Patient Medical History Form

Name: First______________________________Last________________________ Age________

Date of Birth:_____/_____/_____ (MM/DD/YYYY)

Address Street: ____ City: ____________ State: ____ Zip: ________

E-Mail Address:____Occupation:___________________________

Home Phone Number: (_______) -__________-___________

Work Phone Number: (_______) -__________-___________

Mobile Phone Number: (_______) -__________-___________

How did you hear about us? ____

What is the primary reason for your office visit today? List your most problematic symptom.

____

Current Symptoms/Conditions (please check all that apply):

- [ ] Fatigue
- [ ] Night sweats
- [ ] Hot flashes
- [ ] Weight gain
- [ ] Weight loss
- [ ] Medication changes
- [ ] Skin dryness
- [ ] Acne
- [ ] Hair loss
- [ ] Itching
- [ ] Nail changes
- [ ] Water retention
- [ ] Increased body hair
- [ ] Breast tenderness
- [ ] Heart palpitations
- [ ] Constipation
- [ ] Bloating
- [ ] Absence of menstruation
- [ ] Vaginal discharge
- [ ] Cramps
- [ ] Pelvic pain
- [ ] Painful intercourse
- [ ] Vaginal dryness
- [ ] Irregular menstrual cycles
- [ ] Heavy menstrual bleeding
- [ ] Incontinence
- [ ] Joint pain
- [ ] Muscle aches
- [ ] Headaches
- [ ] Memory loss
- [ ] Focus
- [ ] Anxiety
- [ ] Depression
- [ ] Irritability
- [ ] Mood changes
- [ ] Suicidal thoughts
- [ ] Insomnia
- [ ] Early waking
- [ ] Low libido
- [ ] Cold intolerance

When did your symptoms start? ________________

What makes your symptoms better?____

What makes your symptoms worse? ____

Have long have you had your symptoms? ______________________

How would you describe your symptoms? (circle one) Mild / Moderate / Severe

GI Health Related Questions:

Question	Yes	No
Do you experience fatigue and "foggy thinking"?	☐ Yes	☐ No
Do you crave sugar; have a bloated abdomen or abdominal pain?	☐ Yes	☐ No
Do you have recurrent yeast, vaginal, prostate, or urinary tract infections or	☐ Yes	☐ No
Do you have a white coating on your tongue or inside your mouth?	☐ Yes	☐ No
Do you have chronic sinus problems?	☐ Yes	☐ No
Do you have itchy rashes on your skin?	☐ Yes	☐ No
Do you feel 20 to 30 years older than you really are?	☐ Yes	☐ No
Does your long struggle for health cause you depression?	☐ Yes	☐ No
Have you been sent home by doctors who say "nothing is wrong with you" when something is obviously wrong?	☐ Yes	☐ No
Have you taken repeated or prolonged courses of antibacterial drugs?	☐ Yes	☐ No
Are you bothered by hormone disturbances, including PMS, menstrual irregularities, sexual dysfunction, sugar cravings, low body temperature or fatigue?	☐ Yes	☐ No
Are you unusually sensitive to tobacco smoke, perfumes, colognes and other chemical odors?	☐ Yes	☐ No
Are you bothered by memory or concentration problems? Do you sometimes feel spaced out?	☐ Yes	☐ No
Have you taken prolonged courses of prednisone or other steroids for more than 3 years?	☐ Yes	☐ No
Do some foods disagree with you or trigger your symptoms?	☐ Yes	☐ No
Do you suffer with constipation, diarrhea, bloating, or abdominal pain?	☐ Yes	☐ No
Does your skin itch, tingle or burn; or is it unusually dry; or are you bothered by rashes?	☐ Yes	☐ No
Do you have any Food Allergies? If so, to what? ________________________	☐ Yes	☐ No

Allergies to medications ____

Medications (please list dosage if possible) ____

Supplements ____

Family History:

☐ Thyroid disease — Which family member(s) and what type(s)? Member ________ Type __________

☐ Heart disease — Member ________

☐ Stroke — Member ________

☐ Bleeding or clotting — Member ________

☐ Hypertension — Member ________

☐ Cancer — Member ________ Type __________

☐ Diabetes — Member ________ Type __________

☐ Other — Member ________

Personal Past Medical History (check all that apply/please include when diagnosed)

- [ ] Abnormal Pap smear
- [ ] Anxiety disorder/Depression
- [ ] Breast problems
- [ ] Cancer or tumors
- [ ] Cervical problems
- [ ] Diabetes
- [ ] Respiratory problems
- [ ] High blood pressure
- [ ] Hormone problems
- [ ] High cholesterol
- [ ] Migraines
- [ ] Osteoporosis
- [ ] Heartburn
- [ ] Prostate Cancer
- [ ] Stomach/ Bowel problems
- [ ] Stress
- [ ] Thyroid disorder
- [ ] Tuberculosis
- [ ] Endometriosis
- [ ] Fibroids

Surgical History: (please list all surgeries that you have had since birth and indicate the year it was performed)

Surgery____Date Performed __________________

Surgery____Date Performed __________________

Injuries : (please include the year) ____

Hospitalizations: ____

Diagnostic Tests (especially recent cardiac testing, colonoscopies) ___________________________________

Last Pap Test: ____

Last Mammogram or Thermogram: ____

Bone Density: ____

Social History:

Do you drink alchohol? If so, how often? ☐ Yes ☐ No

Do you exercise? If so, how often? ☐ Yes ☐ No

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How many hours of sleep do you get each night? _____ hours

Do you take vitamin supplements? ☐ Yes ☐ No

Do you drink coffee or caffeinated drinks? If so, how many cups per day? ___ ☐ Yes ☐ No

Do you smoke? If so, how many cigarettes or packs per day? ____________ ☐ Yes ☐ No

Is there any other health related issue you can share that might impact your health? _______________ _____ _____ _____ _ ________ _____ ___

Women Only:

First Day of menstrual Cycle____________________ Age First Started Period ____________________

How long do your cycles last? _______________

Women Only (cont):

Do you miss your period or have more than one per month?	☐ Yes	☐ No
Are your periods regular?	☐ Yes	☐ No
Do you experience any heavy bleeding?	☐ Yes	☐ No
Do you have a history of infertility?	☐ Yes	☐ No
Are you on birth control? If yes what method? ______________	☐ Yes	☐ No
How many children do you have? (Circle one) 1 2 3 4 5 more than 5		
Have you ever had a miscarriage? If so, how many? _________ ___	☐ Yes	☐ No
Have you started menopause? If so, when was the onset? ____________	☐ Yes	☐ No
Have you completed menopause? If so, when? ______________	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No

Men Only:

Do you have a history of prostate disease?	☐ Yes	☐ No
Have you ever had a elevated PSA?	☐ Yes	☐ No
Do you have history of prostate enlargement?	☐ Yes	☐ No
Do you have a history of prostate cancer?	☐ Yes	☐ No
Do you have urinary frequency?	☐ Yes	☐ No