

HEALTH HISTORY

Dr. Leah McNeill

2310 130th Ave. NE | Suite B-103

Bellevue, WA 98005 (P)425-881-2310

PATIENT NAME: _____

BIRTHDATE: ____/____/____ SEX: M F

*This history form provides us with information to help us meet all your healthcare needs, please complete both sides of this form answering each question. **This is a confidential part of your medical record and will be kept in this office.***

Today's date _____

When was your last physical exam? _____

Place of Birth _____

Name of doctor _____ Phone _____

Highest level in school _____

Please list all serious illnesses, operations, and other hospitalizations you have experienced and indicate year these occurred:

Occupation _____

Previous occupations _____

Marital status _____

Hobbies _____

Exercise/recreation _____

Habits:

Smoking (type & amount per day) _____

Please list all medicines you are currently taking (include nonprescription drugs):

If former smoker, date quit _____

Alcohol (type & amount per week) _____

Caffeine (type & amount per day) _____

Street drugs (type & amount per day) _____

Usual weight _____ My ideal weight _____

Describe all serious accidents, severe injuries, head injury, fractures or broken bones (include date occurred):

Date of last dental exam _____

Please list all allergies (foods, drugs, environment)

Any history of family violence? _____

CHIEF COMPLAINTS

Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing:

MEDICAL HISTORY

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

- | | | | | | | | | |
|----------------|----|-----|----------------|----|-----|---------------|----|-----|
| •Measles | no | yes | •Rheumatic | | | •Epilepsy | no | yes |
| •Mumps | no | yes | Fever | no | yes | •Migraine | | |
| •Chickenpox | no | yes | •Heart Disease | no | yes | Headaches | no | yes |
| •Whooping | | | •Arthritis | no | yes | •Tuberculosis | no | yes |
| Cough | no | yes | •Venereal | | | •Diabetes | no | yes |
| •Scarlet Fever | no | yes | Disease | no | yes | •Cancer | no | yes |
| •Diphtheria | no | yes | •Anemia | no | yes | •Polio | no | yes |
| •Smallpox | no | yes | •Bladder | | | •Glaucoma | no | yes |
| •Pneumonia | no | yes | Infections | no | yes | •Hernia | no | yes |

HEALTH HISTORY

PATIENT NAME: _____

MEDICAL HISTORY continued

- Blood or Plasma Transfusions no yes
- Back trouble no yes
- High/low Blood Pressure no yes
- Hemorrhoids no yes
- Date of last chest x-ray _____
- Asthma no yes
- Hives/Eczema no yes

- AIDS or HIV+ no yes
- Infectious Mono no yes
- Bronchitis no yes
- Mitral Valve Prolapse no yes
- Stroke no yes
- Hepatitis no yes
- Ulcer no yes
- Kidney disease no yes

- Thyroid Disease no yes
- Bleeding Tendency no yes
- Any other Disease no yes
(Please list)

FAMILY HISTORY

Has any blood relative had any of the following: (Circle "no" or "yes", leave blank if uncertain)

- | | | Relationship |
|-----------------------|--------|--------------|
| •Cancer | no yes | _____ |
| •Tuberculosis | no yes | _____ |
| •Diabetes | no yes | _____ |
| •Heart disease | no yes | _____ |
| •High blood Pressure | no yes | _____ |
| •Stroke | no yes | _____ |
| •Epilepsy | no yes | _____ |
| •Allergies | no yes | _____ |
| •Anemia | no yes | _____ |
| •Bleeding Tendency | no yes | _____ |
| •Asthma | no yes | _____ |
| •Chronic Lung Disease | no yes | _____ |
| •Drug/Alcohol Problem | no yes | _____ |
| •Depression | no yes | _____ |

- | | | Relationship |
|---------------------|--------|--------------|
| •Psychosis | no yes | _____ |
| •Suicide | no yes | _____ |
| •Leukemia | no yes | _____ |
| •Migraine Headaches | no yes | _____ |
| •Obesity | no yes | _____ |
| •Thyroid Disease | no yes | _____ |
| •Ulcer | no yes | _____ |
| •High Cholesterol | no yes | _____ |
| •Kidney Disease | no yes | _____ |
| •Glaucoma | no yes | _____ |
| •Gout | no yes | _____ |

List the present age or the age of death of each of the following members of your family. If living, add whether their health is "good", "fair", or "poor". If deceased, list the cause of death.

Father _____
 Mother _____
 Brother _____
 Sister _____

Spouse _____
 Son _____

 Daughter _____

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SYMPTOM SURVEY

Use the scale below to evaluate any symptoms you have experienced within the last six (6) months.

SCALE OF SYMPTOM POINTS:

- 0 = Do Not Suffer From This Ever or Almost Ever
- 1 = Suffer OCCASSIONALLY (< 2 times p/week), is not severe
- 2 = Suffer FREQUENTLY (2 or more times p/week), not severe
- 3 = Suffer OCCASSIONALLY and is severe
- 4 = Suffer FREQUENTLY and is severe

CONSTITUTIONAL

- _____ Fatigue (sluggish, tired)
- _____ Hyperactive (nervous energy)
- _____ Restless (can't relax/sit still)
- _____ Sleepiness During Day
- _____ Insomnia at Night
- _____ Dizziness

EMOTIONAL/MENTAL

- _____ Depression
- _____ Anxiety (vague fears, uneasiness)
- _____ Mood Swings (rapid distinct changes)
- _____ Irritability
- _____ Forgetfulness

HEAD/EARS

- _____ Headache (any kind)
- _____ Earache
- _____ Ear Infection
- _____ Ringing in Ear
- _____ Itchy Ears
- _____ Discharge From Ears

SKIN

- _____ Blemishes, Acne
- _____ Rashes, Hives
- _____ Eczema
- _____ "Rosy" Cheeks

NASAL/SINUS

- _____ Post Nasal Drip
- _____ Sinus Pain
- _____ Runny Nose
- _____ Stuffy Nose
- _____ Sneezing

MUSCULOSKELETAL

- _____ Joint Pains/Aching
- _____ Stiff Joints
- _____ Muscle Aches
- _____ Stiff Muscles
- _____ Arthritis (Diagnosed)

CARDIOVASCULAR

- _____ Irregular Heartbeat
- _____ High Blood Pressure

DIGESTIVE

- _____ Heartburn/Esoph.Reflux
- _____ Stomach Pains/Cramps
- _____ Intestinal Pains/Cramps
- _____ Constipation
- _____ Diarrhea
- _____ Bloating Sensation
- _____ Gas (of Any Kind)
- _____ Nausea, Vomiting
- _____ Painful Elimination

WEIGHT MANAGEMENT

- _____ **Approximate Weight**
- _____ **Approximate Height**
- _____ Fluctuating Weight

OTHER

- _____ Leg Cramp when sitting
- _____ Feet get cold or numb
- _____ Legs hurt walking a lot
- _____ Sores - legs not healing
- _____ Tingling in the legs
- _____ Sleeping Difficulties

Describe what you typically eat each day:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

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PATIENT NAME: _____

Women only:

- Age period began_____
- # of days period lasts_____
- Days between periods_____
- Is your flow heavy? Yes No Sometimes
- Date of last period_____
- Do you bleed or spot between periods? Yes No Sometimes
- Do you have pain or cramps? Yes No Sometimes
- Date of last pelvic exam_____
- Date of last mammogram_____
- Any itching in the vaginal area? Yes No Sometimes
- Pain with Intercourse? Yes No Sometimes
- Type of birth control used_____
- Number of pregnancies _____
- Number of full term births_____
- Number of preterm births_____

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 health care services I may need.

Patient Signature_____

Date_____

Physician's comment

Physician's Signature_____