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Self Refer Information

This is your medical history form, should be completed prior to your first session. All information will be kept strictly confidential. This information will be used for the evaluation of your health prior to our treatment . The form is extensive, but please try to make it as accurate and complete as possible. Please take your time and complete it carefully and thoroughly, and then review it to be certain you have not left anything out. Your answers will help us design a comprehensive program that meets your individual needs.

If you have questions or concerns, we will help you with those after this form is completed. We realise that some parts of the form will be unclear to you. Do your best to complete the form. Your questions will be thoroughly addressed afterwards. It might be helpful for you to keep a written list of questions or concerns as you complete the medical history form.

Name: _____

Date: _____

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General Information

Participant:

Name _____

Address _____

Contact phone numbers _____

Birth date _____

Ethnic Origin (optional) _____

GP and/or Primary Health Care Provider:

Doctor/Other _____ Phone _____

Address _____ City _____

May I send a copy of your consultation to your physician or primary health care provider and consult with them as necessary?

□ Yes □ No Consent Signature: _____

Marital Status:

□ Single □ Married □ Divorced □ Widowed

Sex:

□ Male □ Female

Occupation:

Position _____

Emergency Contacts:

Name _____ Phone _____

Address _____ City _____

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Present Medical History

Check those questions to which you answer yes (leave the others blank).

- ☑ Has a doctor ever said your blood pressure was too high?
- ☐ Do you ever have pain in your chest or heart?
- ☐ Are you often bothered by a thumping of the heart?
- ☐ Does your heart often race?
- ☐ Do you ever notice extra heartbeats or skipped beats?
- ☐ Are your ankles often badly swollen?
- ☐ Do cold hands or feet trouble you even in hot weather?
- ☐ Has a doctor ever said that you have or have had heart trouble, an abnormal electrocardiogram (ECG or EKG), heart attack or coronary?
- ☐ Do you suffer from frequent cramps in your legs?
- ☐ Do you often have difficulty breathing?
- ☐ Do you get out of breath long before anyone else?
- ☐ Do you sometimes get out of breath when sitting still or sleeping?
- ☐ Has a doctor ever told you your cholesterol level was high?

Comments: _____

_____

_____

_____

Do you now have or have you recently experienced:

- ☐ Chronic, recurrent or morning cough?
- ☐ Episode of coughing up blood?
- ☐ Increased anxiety or depression?
- ☐ Problems with recurrent fatigue, trouble sleeping or increased irritability?
- ☐ Migraine or recurrent headaches?
- ☐ Swollen or painful knees or ankles?
- ☐ Swollen, stiff or painful joints?
- ☐ Pain in your legs after walking short distances?

- ☐ Foot problems?
- ☐ Back problems?
- ☐ Stomach or intestinal problems, such as recurrent heartburn, ulcers, constipation or diarrhoea?
- ☐ Significant vision or hearing problems?
- ☐ Recent change in a wart or a mole?
- ☐ Glaucoma or increased pressure in the eyes?
- ☐ Exposure to loud noises for long periods?
- ☐ An infection such as pneumonia accompanied by a fever?
- ☐ Significant unexplained weight loss?
- ☐ A fever, which can cause dehydration and rapid heart beat?
- ☐ A deep vein thrombosis (blood clot)?
- ☐ A hernia that is causing symptoms?
- ☐ Foot or ankle sores that won't heal?
- ☐ Persistent pain or problems walking after you have fallen?
- ☐ Eye conditions such as bleeding in the retina or detached retina?
- ☐ Cataract or lens transplant?
- ☐ Laser treatment or other eye surgery?

Comments: _____

_____

_____

_____

Women only answer the following. Do you have:

- ☐ Menstrual period problems?
- ☐ Significant childbirth - related problems?
- ☐ Urine loss when you cough, sneeze or laugh?

Date of the last pelvic exam and / or Pap smear _____

Comments: _____

_____

_____

_____

Are you on any type of hormone replacement therapy? _____

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Men and women answer the following:

List any prescription medications you are now taking: _____

_____

_____

List any self-prescribed medications, dietary supplements, or vitamins you are now taking: _____

_____

_____

Date of last complete physical examination: _____

□ Normal □ Abnormal □ Never □ Can't remember

Date of last chest X-ray: _____

□ Normal □ Abnormal □ Never □ Can't remember

Date of last electrocardiogram (EKG or ECG): _____

□ Normal □ Abnormal □ Never □ Can't remember

Date of last dental check up: _____

□ Normal □ Abnormal □ Never □ Can't remember

List any other medical or diagnostic test you have had in the past two years:

_____

_____

List hospitalisations, including dates of and reasons for hospitalisation: _____

_____

_____

List any drug allergies: _____

_____

_____

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Past Medical History

Check those questions to which your answer is yes (leave others blank).

- ☐ Heart attack if so, how many years ago? _____
- ☐ Rheumatic Fever
- ☐ Heart murmur
- ☐ Diseases of the arteries
- ☐ Varicose veins
- ☐ Arthritis of legs or arms
- ☐ Diabetes or abnormal blood-sugar tests
- ☐ Phlebitis (inflammation of a vein)
- ☐ Dizziness or fainting spells
- ☐ Epilepsy or seizures
- ☐ Stroke
- ☐ Diphtheria
- ☐ Scarlet Fever
- ☐ Infectious mononucleosis
- ☐ Nervous or emotional problems
- ☐ Anemia
- ☐ Thyroid problems
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Asthma
- ☐ Abnormal chest X-ray
- ☐ Other lung disease
- ☐ Injuries to back, arms, legs or joint
- ☐ Broken bones
- ☐ Jaundice or gall bladder problems

Comments: _____

_____

_____

_____

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Other Health Risk Factors

Smoking

Have you ever smoked cigarettes, cigars or a pipe?

□ Yes □ No

(If no, skip to diet section)

If you did or now smoke cigarettes, how many per day? _____Age started

If you did or now smoke cigars, how many per day? _____Age started____

If you did or now smoke a pipe, how many pipefuls a day? _____Age started

If you have stopped smoking, when was it? _____

If you now smoke, how long ago did you start? _____

Diet

What do you consider a good weight for yourself? _____

What is the most you have ever weighed (including when pregnant)? _____

How old were you? _____

My current weight is: _____

One year ago my weight was:_____

At age 21 my weight was: _____

Number of meals you usually eat per day: _____

Number of times per week you usually eat the following:

Beef _____ Fish _____Desserts _____

Pork _____ Fowl _____Fried Foods_____

Number of servings (cups, glasses, or containers) per week you usually consume of:

Homogenized (whole) milk _____Buttermilk _____Skim (nonfat) milk _

2% (low-fat) milk _____1% (low-fat) milk _____Coffee _____

Tea (iced or not) _____Regular or diet sodas _____Glasses of water __

Do you ever drink alcoholic beverages?

□ Yes □ No

If yes, what is your approximate intake of these beverages?

Beer:

□ None □ Occasional □ Often If often, _____ per week

Wine:

□ None □ Occasional □ Often If often, _____ per week

Heavy Consumption

□ None □ Occasional □ Often If often, _____ per week

At any time in the past, were you a heavy drinker or used recreational drugs?

□ Yes □ No

Comments: _____

_____

_____

_____

Do you usually use oil or margarine in place of high cholesterol shortening or butter?

□ Yes □ No

Do you usually abstain from extra sugar usage?

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□ Yes □ No

Do you usually add salt at the table?

□ Yes □ No

Do you eat differently on weekends as compared to weekdays?

□ Yes □ No

Comments: _____

_____

_____

_____

I consent for the above information to be used for the purpose if diagnostic treatment plans.

Sign

Print name Date