Health Restoration

Confidential Patient Health Record

Date:___/____/_____

Personal History

Circle One: Divorced Married Single Separated Widowed Birth Date: ____/____/_____ **Age:**_____
First:_____ **Middle:**_____ **Last:** _____ **Gender: Male / Female**
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Phone:(_____)_____-_____ **Cell Phone:** (_____)____-_____ **Cell Carrier:** _____
Fax Phone: (_____) _____-_____ **Email Address:**_____
Work Phone: (_____) _____-_____ **Work Email:**_____
Contact Preference: Home Phone/Cell Phone/Work Phone/Text Message/ Mail/ Email Home/ Email Work

Preferred Language: English Spanish Other Ethnicity Hispanic or Latino Not Hispanic or Latino

Race: American Indian or Alaska Native Asian Black or African American
Native Hawaiian or Other Pacific Islander White Decline

Social Security #: _____-_____-_____ **Driver's License #:** _____ **State:** _____
Spouses Name: _____ **Ages of Children:**_____

Active Medication List

#1) **Brand Name:**_____ **Generic Name**_____ **Prescribed By:**_____
Strength_____ **Dosage**_____ **Frequency**_____ **Duration**_____ **Quantity**_____ **Start Date**_____

#2) Brand Name:_____ **Generic Name**_____ **Prescribed By:**_____
Strength_____ **Dosage**_____ **Frequency**_____ **Durtion**_____ **Quantity**_____ **Start Date**_____

#3) Brand Name:_____ **Generic Name**_____ **Prescribed By:**_____
Strength_____ **Dosage**_____ **Frequency**_____ **Duration**_____ **Quantity**_____ **Start Date**_____

#4) Brand Name:_____ **Generic Name**_____ **Prescribed By:**_____
Strength_____ **Dosage**_____ **Frequency**_____ **Duration**_____ **Quantity** _____ **Start Date**_____

#5) Brand Name:_____ **Generic Name**_____ **Prescribed By:**_____
Strength_____ **Dosage**_____ **Frequency**_____ **Duration**_____ **Quantity** _____ **Start Date**_____

Active Allergy List: (please list any allergies and reactions)

_____

_____

Non-Drug Allergies: **I... Deny Any Non-Drug Allergy (ies)**
Animals Dairy Eggs Food Coloring Mold Pollen Wheat
Other (please be specific): _____

Do you wear any of the following? Yes No. If yes, please mark: Heel Lifts Innersoles Arch Supports Orthotics

Please list any other conditions you feel we should know about even if unrelated: _____

REVIEW OF SYSTEMS – Please fill out all of the sections. If it doesn't apply, mark "DENY"

Constitutional: I... Deny Any Constitutional Issue (s)
Chills | Daytime Somnolence (Drowsiness) | Fatigue | Fever | Night Sweats
Weight Gain | Weight Loss

Eyes/Vision: I... Deny Any Eyes/Vision Issue (s)
Blindness | Blurred Vision | Cataracts | Change in vision | Double Vision
Eye Pain | Field Cuts (visual field defect) | Glaucoma | Itching (around the eyes) | Tearing
Sensitivity to Light | Wears Glasses and/or Contact lenses

Ears, Nose and Throat: I... Deny Any Ears, Nose and Throat Issue (s)
Bleeding | Dental Implants | Dentures | Difficulty Swallowing | Discharge
Dizziness | Ear Drainage | Ear Infection(s) | Ear Pain | Fainting
Headaches | Head Injury (history of) | Hearing Loss | Hoarseness | Loss of Smell
Nasal Congestion | Nose bleeds (frequent) | Post Nasal Drip | Rhinorrhea (Runny nose) | Sinus Infections
Snoring | Sore Throats (frequent) | Tinnitus (Ringing in Ears) | | TMJ problems

Respiration: I... Deny Any Respiratory Issue (s)
Asthma | Cough | Coughing up blood | Shortness of Breath | Sputum Production | Wheezing

Cardiovascular: I... Deny Any Cardiovascular Issue (s)
Angina (chest pain or discomfort) | Chest Pain | Claudication (leg pain or achiness) | Heart Murmor
Heart Problems | Orthopnea (difficulty breathing while lying down) | Palpitations (irregular or forceful beating of the heart)
Paroxysmal Nocturnal Dyspnea (waking at night with shortness of breath) | Shortness of Breath with Exertion or Exercise
Swelling of Legs | Ulcers | Varicose Veins | Pace Maker – When _____

Gastrointestinal: I... Deny Any Gastrointestinal Issue (s)
Abdominal Pain | Belching | Black, Tarry Stools | Constipation | Diarrhea
Difficulty Swallowing | Heartburn | Hemorrhoids | Indigestion | Jaundice (yellowing of the skin)
Nausea | Vomiting | Vomiting Blood | Abnormal Stool Color | Abnormal Stool Consistency
Abnormal Stool Caliber (quality) | Rectal Bleeding | Other _____

Female: I... Deny Any Female Issue (s)
Birth Control Therapy | Breast Lumps/Pain | Burning Urination | Cramps | Frequent Urination
Hormone Therapy | Irregular Menstruation | Urine Retention | Vaginal Bleeding | Vaginal Discharge

Male: I... Deny Any Male Issue (s)
Burning Urination | Erectile Dysfunction | Frequent Urination | Hesitancy/Dribbling | Prostate Problems
Urine Retention

Endocrine: I... Deny Any Endocrine Issue (s)
Cold Intolerance | Diabetes | Excessive Appetite | Excessive Hunger | Excessive Thirst
Frequent Urination | Goiter | Hair Loss | Heat Intolerance | Unusual Hair Growth
Voice Changes – What type? _____ Where? _____

Skin: I... Deny Any Skin Issue (s)
Changes in Nail Texture | Changes in Skin Color | Hair Growth | Hair Loss | Hives | Itching
Paresthesia (numbness, prickling, or tingling) | Rash | History of Skin Disorders | Skin Lesions/Ulcers | Varicosities

Nervous System: I... Deny Any Nervous System Issue (s)
Dizziness | Facial Weakness | Headaches | Limb Weakness | Loss of Consciousness
Loss of Memory | Numbness | Seizures | Sleep Disturbance | Slurred Speech
Stress | Strokes | Tremors | Unsteadiness of Gait

Psychologic: I... Deny Any Psychologic Issue (s)
Anhedonia (inability to experience joy or enjoy life) | Anxiety | Appetite Changes | Behavioral Change(s)
Bipolar Disorder | Confusion | Convulsions | Depression | Insomnia | Memory Loss
Mood Change(s)

Allergy: I... Deny Any Allergy Issue (s)
Anaphylaxis (history of) | Food Intolerance | Itching | Nasal Congestion | Sneezing

Hematology: I... Deny Any Hematologic Issue (s)
Anemia | Bleeding | Blood Clotting | Blood Transfusion(s) | Bruises easily | Fatigue | Lymph Node Swellin

PAST HEALTH HISTORY

Please fill out carefully as these problems can affect your overall course of care.

Childhood Illness: I... Deny Any Childhood Illness (es)

ADD	Allergies/Hayfever	Asthma	Atopic Dermatitis (Eczema)	Bedwetting
Cerebral Palsy	Chicken Pox	Depression	Diabetes	Ear Infections
Fetal Drug Exposure	Food Allergies	Headaches	Hepatitis	HIV
Measles	Mumps	Rash	Scoliosis	Seizure Disorder
Sickle Cell Anemia	Spina Bifida	Other (please describe): _____		

Adult Illness: I... Deny Any Adult Illness (es)

Alzheimer's	Anemia	Arthritis	Asthma	Cancer
Chicken Pox	Crohn's/Colitis	CRPS (RSD)	CVA (stroke)	Cystic Kidney Disease
Depression	Diabetes (Insulin)	Diabetes (Non insulin)	Ear Infections (frequent)	Emphysema
E ye Problems	Fibromyalgia	Heart Disease	Hepatitis	HIV
Hypertension	Influenzal Pneumonia	Liver Disease	Lung Disease	Lupus Erythema (discoid)
Lupus Erythema (systemic)	Multiple Sclerosis	Parkinson's Disease	Pleurisy	Pneumonia
Psychiatric Problems	Scoliosis	Seizure Disorder	Shingles	STD's (unspecified)
Suicide Attempt(s)	Thyroid Problems	Vertigo		

Past history of similar symptoms to your current condition Other Illness (please be specific): _____

Surgeries: Deny Any Surgery (ies) *** PLEASE TELL US THE YEAR OF EACH APPLICABLE SURGERY***

Angioplasty_____	Appendectomy_____	Caesarian Section_____	Cardiac Catheterization____	Carpal Tunnel Repair____
Coronary Artery Bypass_____	Cosmetic_____	D & C_____	Dental Surgery_____	Gallbladder_____
Hemorrhoidectomy____	Hernia Repair_____	Hysterectomy_____	Joint Reconstruction_____	Joint Replacement_____
Laminectomy_____	Mastectomy_____	Pacemaker Insertion____	Rotator Cuff _____	Spinal Fusion _____
Tonsillectomy_____	Other (please be specific): _____			

Ob/Gyn: I... Deny Any Ob/Gyn Issue (s)

I... have never been pregnant	have been pregnant in the past	am currently pregnant
_____ Number of pregnancies	_____ Number of complicated pregnancies	_____ Number of uncomplicated pregnancies
_____ Number of miscarriages	_____ Number of terminated pregnancies	_____ Number of Epidural Injections
_____ Number of C-Sections	_____ Number of vaginal deliveries	

Menstrual History: Age of Onset _____

My menses is Regular Irregular; I am currently in Perimenopausal Menopause; Date of Last Menses _____/_____/_____

Injuries: I... Deny Any Injury (ies)

Back Injury Broken Bones / When_____ Fracture / Where & When _____
Head Injury Industrial Accident Joint Injury / Where_____ Severe Laceration
Mild/Moderate Soft Tissue Injury / Where_____ Severe Soft Tissue Injury / Where & When_____ Severe Fall
Motor Vehicle Accident / When _____ Disability _____

Immunizations: I... Deny Any Immunization (s)

DTaP(diptheria, tetanus, and pertussis)	Flu	Hepatitis A	Hepatitis B	Hepatitis C
Influenza	IPV (Polio)	MMR (measles, mumps, and rubella)	Pneumococcal	
PPD (Mantoux Test-TB)	Small Pox	TB	Varivax (chicken pox)	Whooping Cough (Pertussis)

Family History

						Condition (please be specific)
General Family	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had:	
Father	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had:	
Mother	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had:	
Paternal Grandfather	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had:	
Paternal Grandmother	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had:	
Maternal Grandfather	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had:	
Maternal Grandmother	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had:	
Son (s)	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had:	
Daughter (s)	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had:	
Brother (s)	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had:	
Sister (s)	Alive	Deceased;	Normally Developed	No Significant Disease	Has/Had:	

Social History

Alcohol: Never Social Consumption only Beer Liquor Wine ; _____ oz ____ glasses; Day Week Month

Diet (please mark all that apply): High Fat High Fiber High Protein High Salt
Low Calorie Low Carb Low Fiber Low Salt Low Sugar

Education (please mark the highest level completed): Preschool Elementary Middle Junior High Votech
In High School Did Not Finish High School High School Diploma Post High School Classes Assoc/Technical Degree
In College College Degree In Graduate School Graduate Degree Doctorate Other: _____

Drugs: Deny any illegal drug use Deny use of IV drugs Have not used drugs since _____
Have used drugs for _____

Tobacco: Deny Tobacco Use Do not smoke cigars, cigarettes or pipe Live with a smoker Quit smoking
Smoke; # _____ per Day Week Month Chew; #_____cans per Day Week Year

Please list any other conditions you feel we should know about – even if unrelated:

_____

_____

_____

Signature of Patient or Legal Guardian:_____ **Date:**_____

Scribed by_____ **Relationship to patient**_____