Camden Whole Health

91 Elm Street Camden, ME ~ (207) 230-1131

Date: _____

Patient Info:

Name: _____

Phone: _____(H)_____(C)

(*Circle # where we can leave a voice message*)

Address: _____

_____

E-mail: _____

Add you to Camden Whole Health's e-mail list? (Y) (N)

In Case of Emergency Contact:

Name: _____
Phone: _____
Relationship: _____

PERSONAL INFORMATION

Date of Birth: _____
Age: _____ SS#: _____
Employer: _____
Address: _____

SOCIAL HISTORY

Occupation: _____

Years: _____ Satisfied? _____

Marital Status: _____

Do you have any children? _____

Do you take care of anyone besides your children?

_____

 # HOURs you spend doing the following:

TV (per day): _____ Outdoors (per day): _____

Working (per work day): _____

List any major hobbies: _____

_____

Religious/spiritual preferences: _____

Have you ever been physically, mentally or sexually abused:_

Do you feel safe at home? _____

EXERCISE

Do you exercise as much as you would like to? Y N

Goals: # days/week _____ #minutes _____

Types: _____

Height: _____ Weight: _____

HEALTH CONCERNS

Please list in order of importance (to you) any health concerns you would like to address here:

1. _____
2. _____
3. _____
4. _____
5. _____

List any other MAJOR MEDICAL CONDITIONS you have now or have had in the past: _____

_____
_____
_____
_____

List any SURGERIES or HOSPITALIZATIONS: _____

_____
_____
_____

List all PRESCRIPTION DRUGS and the name of the prescribing DOCTOR:

_____
_____
_____
_____
_____
_____

Are you ALLERGIC to any medications? Y N
If Yes, which: _____

List all OVER THE COUNTER medications, vitamins, supplements and herbal formulas that you use on a regular basis: _____

_____
_____
_____
_____
_____
_____

List all other physicians, alternative care providers and therapists you see regularly: _____

_____
_____
_____
_____

How did you hear about our practice? _____

_____
_____

If you were referred by someone, would you mind sharing who referred you? _____

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FAMILY HISTORY

Please indicate which conditions listed below an immediate family member has experienced.

G=Grandparent **P**=Parent **S**=Sibling **C**=Child

Heart Disease or Heart Attack:_____ G P S C
High Cholesterol:_____ G P S C
Diabetes (Type 2/Adult):_____ G P S C
Rheumatoid Arthritis:_____ G P S C
Auto-Immune Disease:_____ G P S C
Type:_____
Liver Disease_____ G P S C
Kidney Disease _____ G P S C
Cancer:
Type:_____ G P S C
Type:_____ G P S C
Type:_____ G P S C
Epilepsy _____ G P S C
Stroke _____ G P S C
Mental Illness _____ G P S C
Glaucoma _____ G P S C
Cataracts _____ G P S C
Asthma _____ G P S C
Eczema _____ G P S C
Hay fever or Hives _____ G P S C
Other Conditions not listed above:
_____ G P S C
_____ G P S C

LIFESTYLE

Sleep: Average # hours per night: _____
Usual time to bed: _____
Usual time you get up: _____
Are you satisfied with your sleep? Y N
Explain: _____

Energy: Do you wake rested? Y N
When is your energy best? _____
When is your energy lowest? _____

Mood: Are you satisfied with your mood? Y N
Explain: _____

Have you ever been treated for?
Personality Disorder: ___ Depression: ___ Anxiety: __

Do use **tobacco**? Y N
Have you ever used tobacco? Y N
Years: _____ #Packs/day: _____

Do you consume **alcohol**, **beer +/or wine**? Y N
Servings day: _____

Do you consume **caffeine**? Y N
Servings day: _____

VACCINATIONS

Circle all vaccinations you have received:

DPT:	Diphtheria	Pertussis	Tetanus
MMR:	Measles	Mumps	Rubella
Polio	Hepatitis B	Chicken Pox	Other

SPECIALIZED TESTING

Have you had any of the following (circle & explain):

Ultrasound MRI CT scans X-Ray
Endoscopy Colonoscopy BoneDensityScan
Explain: _____
_____

SEXUALITY: Heterosexual: __ Homosexual: __
Bisexual: __ Transgender: __

MEN'S HEALTH

Have you ever experienced any of the following?

Prostate Issues	Y	N
Dribbling Urine or Difficulty Starting	Y	N
Premature Ejaculation	Y	N
Erectile Dysfunction	Y	N
Testicular Pain or Masses	Y	N

WOMEN'S HEALTH

Age of first menses _____
Age of last menses (if menopausal) _____
Length of Cycle (e.g. 28 days)_____
Duration of Cycle (e.g. 5 days)_____
Date of last GYN exam or Pap smear:_____
Do you do self breast exams? Y N

Have you ever experienced any of the following?

Vaginitis	Y	N
Sexually Transmitted Disease	Y	N
Irregular cycles	Y	N
Painful menses	Y	N
Endometriosis	Y	N
Heavy Flow	Y	N
Spotting between menses	Y	N
Ovarian cysts	Y	N
Cervical dysplasia or an "Abnormal Pap"	Y	N
Breast tenderness	Y	N
Abnormal Mammogram	Y	N
Breast mass or lump	Y	N
Nipple discharge	Y	N
PMS	Y	N

If yes describe: _____
Menopausal Symptoms Y N
If yes describe: _____
Do you use Birth Control? Y N
If yes describe: _____
Pregnancies:_____
Miscarriages:_____
Abortions:_____
Live Births:_____

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Adoptions: _____
Problems in Pregnancy or Labor: _____

Gastrointestinal:

Do you have a history of, or currently experience?

Diarrhea	Y	N
Constipation	Y	N
Blood, mucus in stool	Y	N
Crohn's Disease	Y	N
Ulcerative Colitis	Y	N
Colon Cancer	Y	N
Colon Polyps	Y	N
Irritable Bowel Syndrome	Y	N
Intestinal Parasite	Y	N
Infection: Candida	Y	N
: Bacteria	Y	N

Urinary:

Do you now, or in the past, have had frequent urinary tract infections?	Y	N
Leakage of urine	Y	N

Have you ever experienced, or been screened for any of the following? Please describe:

Thyroid disorder	Y	N
Cardiac/heart related issues	Y	N
Lung disease	Y	N
Skin disease or disorder	Y	N
Mononucleosis or other viral issues	Y	N
Cancer	Y	N
Autoimmune disease	Y	N
Lyme disease or other tick – borne illness	Y	N

ADDITIONAL INFORMATION: