

HEALTH ASSESSMENT/REGISTRATION FORM



NAME: _____

ADDRESS: _____

PHONE: day _____ eve _____

EMAIL: _____

EMERGENCY CONTACT: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

I have read the information letter given to me with this packet and agree to the policies explained in that letter. I request medical treatment and care from Dr. Lisa Lichtig. I agree to pay in full at the time of service. I understand that non-standard therapies may be offered or recommended. _____ (signature)
_____ (date)

MEDICAL HISTORY

Current Medical History

Describe your main health concern

List any current illnesses (include age or date of onset)

List other current Health Practitioners or previous MD

Medication Allergies (include reaction)

Medications/Supplements (list all and bring all on your first visits)

Lisa's Health Hx.doc
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Past Medical History

Share any known history of your birth

Childhood Illnesses (with approximate date/age)

Previous Illnesses (with approximate date/ age)

Hospitalizations (with approximate date/age)

Operations (with approximate date/ age)

Accidents (include approximate date or age)

Reproductive History

Onset of Menses (age) ____

Number of pregnancies ____

Number of live births ____

Number of miscarriages ____

Previous Contraception _____

Onset of Menopause @ age ____

Preventive Medicine

Immunizations

Tetanus (Date) _____

Hepatitis B (Date) _____

FluVAX (Date) _____

Other _____

Tests

Cholesterol _____

Colonoscopy (Date) _____

PSA (Date) _____

Mammogram (Date) _____

Pap Smear (Date) _____

Bone Density (Date) _____

FAMILY & SOCIAL HISTORY

Current Relationship:

Single? _____ Married? _____ Divorced? Year ____

In Significant Relationship? _____

List the people in your current household (name, relationship, current age, and health problems):

List the people who were in your house growing up (name, relationship, current age, and health problems)

Family Health History

State problem and age of occurrence

Mother _____

Father _____

Paternal GF _____

Paternal GM _____

Maternal GF _____

Maternal GM _____

Aunts/ Uncles _____

Siblings _____

Where did you grow up? _____

Educational History

What is the highest grade in school completed? _____

Degree, Date, Place (if applicable)

Occupational History

Current Job _____

Significant past employment: _____

WELLNESS HISTORY

Diet (Typical day)

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Supplements (List)

Substances

How many drinks of alcohol do you drink in one week? ____

Caffeine/ Coffee (Drinks/ day) _____

Did you ever smoke? yes/no

of packs/day? _ # of years? _____

Did you currently smoke? yes/no

of packs/day? ____ # of years? _____

If you quit, when did you quit? _____

Have you ever used smokeless tobacco? yes/no

Exercise

Type _____

How often _____

Recreation/ Fun

What do you do for recreation?

Pets

Do you have any pets? List.

Safety

Have you been in any accidents? _____

What % do you use your seatbelt? _____

Do you use the cell phone while driving _____

What % do you wear a bike helmet? _____

Environmental Exposures

Time spent in front of a computer? _____

Time watching TV? _____

Time spent on a cell phone? _____

Belief Systems

Please say something about your spiritual life

REVIEW OF SYSTEMS

(Circle all that currently apply)

General

Weight Loss or Weight Gain
Night Sweats
Chronic Fatigue
Intolerant of Heat/Cold
Excessive Thirst

Skin

Rashes/ Moles
Warts/ Lumps/bumps
Hives/ Itching/ Dry Skin
Fungal infection / Poison Ivy
Pimples/ Acne
Easy Bruising/ Skin Cancer

Hair

Dandruff
Unwanted hair/ Hair Loss
Hair coloring or permanent

Eyes

Glasses/Contacts
Eye Pain/ Blurriness
Watery, Itchy Eyes
Double Vision/ Loss of Vision
Glaucoma/ Cataracts

Ears

ringing/ Hearing loss
Chronic Ear Infections
Swimmers Ear/ Ear Wax

Nose & Sinus

Frequent Colds/ Nose Bleeds
Hayfever/ Allergies/Sneezing
Congestion/Sinus Pressure/ Pain

Mouth & Throat

Cavities/Fillings/Dentures
Recent Extractions/ Gum problems
Bad breath
Tooth Pain/ Throat Pain
Jaw clicking/ Teeth clenching/ Facial Pain
Canker Sores
Hoarseness
Speech Problems

Neck

Pain/ Stiffness
Swollen lymph glands

Breast

Pain/ Lumps
Nipple Discharge
Cysts (Fibrocystic)

Respiratory

Cough (productive or dry)
Shortness of breath/ Wheezing
Recurrent Infections
Smoker
Conscious of Breathing?

CardioVascular

Chest Pain/ Angina
Swelling of ankles or legs
Irregular Heart Beat
Fainting Spells
Sleep with extra pillows
Awaken with trouble breathing
Cold hands and feet
Varicose veins
Leg Cramps @ rest/ while walking

Digestion

Poor Appetite/ Excessive Hunger
Food Allergies or sensitivities
Difficulty swallowing
Nausea/ Vomiting
Belching/ Heartburn/ Regurgitation
Cramping/ Bloating
Flatus/gas
Upper/Lower Abdominal Pain
Jaundice
Diarrhea/ Constipation
Hemorrhoids/ Rectal Pain/Itching
of stools/day ____
Bloody/ Black Stools

Urinary

Frequency or pain
Difficulty starting/stopping stream
Leakage of urine/ incontinence
Wake up to urinate, # of times ____
Bed Wetting

Reproductive

Female

Last Menstrual Period _____
Type of contraception _____
Days between cycles:
<21 / 22-25 / 26-30 / >31/ irregular
PMS symptoms
Constipation/ Swelling
Moodiness/ depression/ irritability
Sore breast/ sugar cravings
Symptoms with Period
Cramping/Clotting
Heavy or Minimal Flow
Days of flow ____
Hot flashes
Vaginal dryness/itching
Vaginal discharge/ irritation
Vaginal pain/Pelvic pain
Hot flashes

Men

Penile discharge
Scrotum pain/ lumps
Loss of erection

Sexual

Sexually active

Are you satisfied with your sexual life
Problems with sexual arousal
Pain with intercourse
History of sexual trauma
History of Sexually transmitted infections

Neurologic

Headaches/ Seizures
Loss of consciousness/ Foginess
Poor memory/ Difficulty
Dizziness/ Vertigo
Trouble with balance
Tremors/ Shakiness
Loss of sensation/ numbness

MusculoSkeletal

Joint Pain/ Stiffness/ Swelling
Muscle weakness/pain
Back Trouble

Psychological

Nervousness/Anxious/Excess worry
Depression
Irritability
Thoughts of Suicide
Marital problems

Sleep

When do you go to sleep?
When do you awaken?
Difficulty falling asleep/ staying
Difficulty going back to sleep
Recurrent dreams or Nightmares
Daytime sleepiness/ Snoring
Do you take anything to help you sleep

OTHER please list any additional symptoms below

