COMPREHENSIVE HEALTH PROFILE

Name _____ DATE _____

Address _____ City _____State _____ Zip _____

Age ____ Birthdate _____ Relationship status: M S W D P I identify my gender as: _____

Email Address _____ Occupation _____

Cell Phone _____ Home Phone _____ Work Phone _____

Referred by _____

Nearest friend or relative who may be called in an emergency:

Name _____ Relationship _____

Address _____ Phone Number _____

Instructions: ***Put a check in those boxes applicable to you. When necessary write in your answer.***

1) REASON FOR TODAY'S VISIT: _____

_____

2) ILLNESSES / INJURIES

Have you had:

- ❑ Mumps
- ❑ Measles
- ❑ Rubella
- ❑ Chickenpox
- ❑ Whooping cough
- ❑ Pneumonia
- ❑ Rheumatic
- ❑ Polio
- ❑ Mononucleosis
- ❑ Tuberculosis (TB)
- ❑ Venereal disease (VD)
- ❑ Frequent colds or infection
- ❑ Any broken bones
- ❑ Head injury
- ❑ Poisoning of any kind
- ❑ Skin disorders
- ❑ Recurring headaches
- ❑ Glaucoma
- ❑ Asthma
- ❑ Heart problems
- ❑ High blood pressure
- ❑ Peptic ulcer
- ❑ Liver/gallbladder disease
- ❑ Hemorrhoids
- ❑ Kidney problems
- ❑ Arthritis
- ❑ Recurring backache
- ❑ Nervous breakdown
- ❑ Diabetes
- ❑ Thyroid problems
- ❑ COVID-19
- ❑ COVID-19: Long COVID

List any other illness or injuries:

- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

3) SURGERY / HOSPITALIZATIONS

Have you had removed:	When?
❑ Tonsils	_____
❑ Appendix	_____
❑ Gallbladder	_____
❑ Uterus (hysterectomy)	_____
❑ One or both ovaries	_____

List any operations or periods of hospitalization for any illness

- ❑ _____
- ❑ _____
- ❑ _____
- ❑ _____

4) IMMUNIZATIONS

Have you had any of the following immunizations:

- ❑ Polio
- ❑ Diphtheria/ pertussis/ tetanus (DPT)
- ❑ Measles
- ❑ Mumps
- ❑ Smallpox
- ❑ Tetanus booster (last ten years)

❑ COVID-19:
which one: _____
date/s: _____

List any others:

- ❑ _____
- ❑ _____
- ❑ _____

5) ALLERGIES

Are you allergic to any: ❑ Foods ❑ Drugs or medication ❑ Other substances

List: _____

6) MEDICATIONS

Do you regularly take:

❑ Digestive enzymes
❑ Laxatives
❑ Antacids
❑ Aspirin and cold medicines
❑ Sedatives
❑ Diet pills
❑ Cortisone
❑ List any other medications you are currently taking: _____
❑ Sleeping pills
❑ Thyroid (grains per day____)
❑ Estrogen

_____

7) HABITS / ENVIRONMENT

Do you:

❑ Awaken feeling unrested
❑ Have trouble sleeping
❑ Have problems with constipation
❑ Exercise: (how much – how often?)
❑ Have problems at work, home
❑ Have trouble relaxing or enjoying your spare time
❑ Drink alcohol (how much? _____)
❑ Drink coffee (cups per day _____)
❑ Smoke tobacco (packs per day _____)

Have you been treated for:

❑ Alcoholism
❑ Drug abuse
❑ Eating disorder

8) DIET

Do you:

❑ Feel your diet is adequate
❑ Eat at irregular intervals
❑ Eat in a hurried atmosphere
❑ Eat quickly and forget to chew
❑ Eat between meals
❑ Drink with meals
❑ Eat out often (more than once a week)
❑ Follow a special or restricted diet
❑ Regularly drink "softened" water
❑ Regularly salt your food
❑ Regularly eat fried foods
❑ Use sugar on your food or in drinks
❑ Use sugar in cooking
❑ Eat foods with artificial coloring
❑ Or flavoring, preservatives
❑ Avoid certain foods

List any vitamins, minerals, or other dietary supplements you are taking (or list on separate sheet): _____

_____

_____

9) FAMILY HISTORY

Which member of your family or near relative had:

❑ Diabetes
❑ Tuberculosis
❑ Heart problems
❑ Kidney problems
❑ Cancer
❑ High blood pressure
❑ Stroke
❑ Epilepsy
❑ Nervous breakdown
❑ Asthma
❑ Hives or hay fever
❑ Arthritis or gout
❑ Thyroid problems
❑ Bleeding problems
❑ Weight problems

10) WOMEN ONLY: MENSTRUAL HISTORY / PREGNANCIES

Do you have:

❑ Irregular periods
❑ Cramps or pain with period
❑ Tension or depression before period
❑ Breast tenderness before period
❑ Hot flashes at any time
❑ Pain during intercourse
❑ Any unusual bleeding or discharge

Are you:

❑ Pregnant or possibly pregnant
❑ Having problems getting pregnant
❑ Using any method of birth control
What kind: _____

Age onset of menses: _____
Age at menopause _____
Usual length of cycle: _____days
Usual duration of flow: _____days
Is your flow: Light Medium Heavy
Date last period began: _____
Date of last PAP: _____

Number of:

_____ children born alive
_____ caesarian sections
_____ premature births
_____ stillborn
_____ miscarriages
_____ abortions