Vitalia HEALTHCARE

PATIENT PROFILE

Date: _____ Full Name: _____

Birthdate: _____ Age: _____ Gender: ❒ Male ❒ Female

Address: _____

_____ Email address: _____

Phone # (Work): _____ Phone # (Home): _____

Primary Physician: _____ Phone #: _____

Emergency Contact Name and Phone number: _____

Known Allergies (Foods, Drugs, Vaccines, Or Environmental): _____

How did you hear about our clinic? _____

Current Health Concerns (Please list in the order of priority to you)

1) _____

2) _____

3) _____

4) _____

5) _____

Current Medications (Prescription, Over The Counter Drugs, Vitamins, Herbs, Homeopathic Remedies, Etc...)

1) _____ Dosage _____ 6) _____ Dosage _____

2) _____ Dosage _____ 7) _____ Dosage _____

3) _____ Dosage _____ 8) _____ Dosage _____

4) _____ Dosage _____ 9) _____ Dosage _____

5) _____ Dosage _____ 10) _____ Dosage _____

Hospitalization (when, for what, and how long):

_____

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Patient Profile

Accidents and injuries: _____

Psychiatric Illnesses: _____

Last Complete Physical Exam Date: _____ Describe Any Abnormal Findings: _____

Last PAP Smear Date: _____ Results: ❒ Normal ❒ Abnormal

Last Mammogram Date: _____ Results: ❒ Normal ❒ Abnormal

Do you do monthly self-breast exams? ❒Yes ❒ No

PERSONAL LIFESTYLE

Tobacco use: ❒ No ❒ Yes How long? _____ Cigarettes Per Day? _____

Caffeine Consumption (Coffee, Tea, Soft Drink): ❒ No ❒ Yes Daily Intake _____

Alcohol consumption: ❒ No ❒ Yes Daily Intake _____

Recreational drug use: ❒ No ❒ Yes Type _____ Amount _____

Describe your average meals:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

List foods that you crave: _____

Describe any diet restrictions or regimens that you follow: _____

How many glasses/liters of water do you drink per day? _____

Average hours of sleep per night: _____ Do you take pills or herbs to help you sleep? ❒ No ❒ Yes

Do you have difficulty sleeping? ❒ Daily ❒ Often ❒ Sometimes ❒ Never

Do you dream? ❒ Daily ❒ Often ❒ Sometimes ❒ Never

SOCIAL HISTORY

Marital status ❒ Single ❒ Married ❒ Significant other/Common law ❒ Widowed

Sexually Active: ❒ No ❒ Yes Birth Control: _____ # of Children: _____ Ages: _____

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FAMILY HISTORY (Check And Fill In All Applicable Boxes):

	Relationship	Comments		Relationship	Comments
Allergies			Heart Disease		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Auto Immune Disease			Kidney Disease		
Asthma			Mental Illness		
Cancer			Stroke		
Diabetes			Tuberculosis		
Epilepsy			Other		

REVIEW OF SYTEMS

For each of the following symptoms/illnesses, please circle the appropriate letter or fill in the information.

Y = Presently Have P = Had In The Past N = Never Had

GENERAL

Chills Or Fever	Y	P	N	Unusual Weight Loss	Y	P	N
Unusual Weight Gain	Y	P	N	Night Sweat	Y	P	N
Swollen Lymph Nodes	Y	P	N	Weakness Or Fatigue	Y	P	N

SKIN

Bruise Easily	Y	P	N	Wounds That Will Not H :al	Y	P	N
Unusual Growths Or Lumps	Y	P	N	Local Skin Color Change	Y	P	N
Rashes	Y	P	N	Unusually Dry	Y	P	N

HEAD/EYES/EAR/NOSE/THROAT

Headache	Y	P	N	Excessive Tearing	Y	P	N
Ringing In Ears	Y	P	N	Vertigo	Y	P	N
Ear Infection	Y	P	N	Ear Discharge	Y	P	N
Frequent Colds	Y	P	N	Nasal Stuffiness	Y	P	N
Nosebleeds	Y	P	N	Nasal Discharge	Y	P	N

RESPIRATORY

Cough	Y	P	N
Sputum/phlegm	Y	P	N
Shortness of breath	Y	P	N

GASTROINTESTINAL

Heartburn	Y	P	N
Blood/Tarry Stool	Y	P	N
Too Much Gas	Y	P	N
Abdominal Pain	Y	P	N
Fatty Food Intolerance	Y	P	N
Constipation	Y	P	N
Diarrhea	Y	P	N

CARDIOVASCULAR

High Blood Pressure	Y	P	N
Chest Pain/Tightness	Y	P	N
Irregular Heart Beat	Y	P	N
Difficulty Breathing	Y	P	N
Leg Muscle Pain After Short Walk	Y	P	N

GENITOURINARY

Painful Urination	Y	P	N
Frequent Urination	Y	P	N
Kidney Stones	Y	P	N
Urgent Urination	Y	P	N
Impotence	Y	P	N
STD or VD	Y	P	N

Have to get up to urinate _____times per night.

NEUROPSYCHOLOGICAL

Seizures	Y	P	N	Depression	Y	P	N
Poor Memory	Y	P	N	Stressed Easily	Y	P	N
Easily Anxious	Y	P	N	Mood Swings	Y	P	N
Numbness In Any Body Parts	Y	P	N	Insomnia	Y	P	N

Patient Profile

GYNECOLOGICAL

Vaginal Discharge	Y	P	N	Vaginal Sores	Y	P	N
Breast Lumps	Y	P	N	Nipple Discharge	Y	P	N
Vaginal Itching	Y	P	N				
Days Between Period	_____			Duration Of Period	_____		
Irregular Period	Y	P	N				
Mid Cycle Bleeding	Y	P	N	PMS	Y	P	N
Painful Menses	Y	P	N	Sexually Active	Y	P	N
Type Of Birth Control	_____			# Of Pregnancies	_____		
# Of Deliveries	_____			# Of Abortions	_____		
Pain During Sex	Y	P	N	Age At Menopause	_____		

ENDOCRINE

Goiter	Y	P	N
Cold Intolerance	Y	P	N
Excessive Sweating	Y	P	N
Excessive Thirst	Y	P	N
Hair Texture Change	Y	P	N

MUSCULOSKELETAL

Muscle Pain	Y	P	N
Joint Pain/Stiffness	Y	P	N
Muscle Atrophy	Y	P	N

Would you like to receive our monthly newsletter by email? _____Yes _____No

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