Dr. Miller's Family Tree
Medical Center

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Ph: (415) 785-3347

CONFIDENTIAL PATIENT HEALTH RECORD

PATIENT INFORMATION

Name: _____
Last First Middle

Address: _____
Street Apt. #

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Birthdate: ___/___/___ Age: ____ Gender: M / F Occupation: _____

Marital Status: ☐ single ☐ partnered ☐ married ☐ divorced ☐ widowed ☐ separated

Email address: _____ Partner's Name: _____

Whom may we thank for referring you? _____
(Or how did you hear about us?)

GUARDIAN OR PARENT INFORMATION (IF PATIENT IS A CHILD)

Name: _____
First Middle Last

Address: _____
(if different from patient information) Street Apt. #

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Relationship to patient: _____ Occupation: _____

Marital Status: ☐ single ☐ partnered ☐ married ☐ divorced ☐ widowed ☐ separated

Social Security #: _____ Partner's Name: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone Number: _____ Alt. Number: _____

Name: _____ Relationship: _____

Phone Number: _____ Alt. Number: _____

Name of Primary Care Physician: _____ Phone: _____

REASON(S) FOR SEEKING CARE

Please list your main health concern(s) *in priority order*:

Problem/Concern/Symptom:	Date of Onset
1st	
2nd	
3rd	
4th	
5th	
6th	
7th	

HEALTH HISTORY

Please check ☑ symptoms you *currently* have or have had in the *past year*:

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation (<1 stool/day)
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Parasites

EYE/EAR/NOSE/THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Ear ache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus infections
- ☐ Vision "flashes"
- ☐ Vision "halos"

CARDIOVASCULAR
- ☐ Chest pain/ pressure
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Varicose veins

SKIN
- ☐ Acne
- ☐ Bruise easily
- ☐ Itching
- ☐ Change in mole(s)
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MUSCLE/JOINT/BONE

Pain, weakness, or numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders
- ☐ Loss of height

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

HEALTH HISTORY (continued)

Please check ☑ conditions you currently have or have had:

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV positive
- ☐ Hypoglycemia
- ☐ IBS/colitis
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine headaches
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problems
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Spontaneous abortion (miscarriage)
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease
- ☐ Weight gain/loss
- ☐ Other: _____

FAMILY HISTORY

- ☐ AIDS/HIV+
- ☐ Alcoholism
- ☐ Allergies/hay fever
- ☐ Arthritis
- ☐ Asthma
- ☐ Breast cancer
- ☐ Cervical cancer
- ☐ Ovarian cancer
- ☐ Prostate cancer
- ☐ Uterine cancer
- ☐ Other cancer: _____
- ☐ Diabetes
- ☐ Eczema
- ☐ Gout
- ☐ Heart disease
- ☐ Hemophilia
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Loss of height
- ☐ Mental illness
- ☐ Migraines
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Psoriasis
- ☐ Senility
- ☐ Seizures
- ☐ Skin problems
- ☐ Stroke
- ☐ Suicide
- ☐ Tuberculosis
- ☐ Thyroid problems
- ☐ Ulcer
- ☐ Other: _____

MEN ONLY

- ☐ Breast lump
- ☐ DES –your mother took during pregnancy
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Erection difficulties

Date of last genital exam: _____

Date of last prostate exam: _____

Date of last PSA test: _____ Results: _____

WOMEN ONLY

- ☐ Abnormal PAP smear*
- ☐ Bleeding between periods
- ☐ Bloating before period
- ☐ Breast lump or pain
- ☐ Currently pregnant
- ☐ DES – your mother took during pregnancy
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Hot flashes
- ☐ Irregular menses
- ☐ Menstrual pain/cramps
- ☐ Nipple discharge
- ☐ Oral contraceptive use (past / present)
- ☐ Ovaries removed (1 / both); when: _____
- ☐ Painful breasts before period
- ☐ Painful intercourse
- ☐ Planning to become pregnant; when:_____
- ☐ PMS
- ☐ Recurring vaginal yeast infections
- ☐ Sexual abuse
- ☐ Spotting instead of period
- ☐ Uterus removed; when: _____
- ☐ Vaginal discharge
- ☐ Vaginal dryness
- ☐ Weight gain prior to menses
- ☐ Other: _____

*Date of abnormal PAP: _____ Results: _____ Therapy: _____

Age at which period began:_____ Date of Last Menstrual Period: _____
Length of menstrual cycle: _____
Duration of menstrual flow: _____ Flow: ☐ Light ☐ Medium ☐ Heavy
Date of last pelvic exam: _____ Results: _____
Date of last PAP smear: _____ Results: _____
Date of last mammogram: _____ Results: _____
Do you perform monthly breast exams on yourself? ☐ No ☐ Yes

Are you sexually active? ☐ Yes ☐ No Form of birth control used: _____

Prior # of pregnancies: _____ # of births: _____ # of miscarriages: _____ # of abortions: _____
Complications? ☐ No ☐ Yes Please describe: _____
C-sections? ☐ No ☐ Yes

CURRENT MEDICATIONS, VITAMINS, & HERB SUPPLEMENTS: (Please include dosages)

_____
_____
_____
_____
_____

HOSPITALIZATIONS, SURGERIES, OR SERIOUS INJURIES: (Please include dates)

_____
_____
_____
_____
_____

_____

ALLERGIES (drugs, food, or other substances):

_____

_____

_____

PERSONAL HEALTH HABITS

Tobacco use: ☐ No ☐ Yes ☐ Previously—Year Stopped: _____
Smoke or Chew? (circle one) How long? _____ Amount per day: _____
Alcohol use: ☐ No ☐ Yes Drinks per week: _____ Type of alcohol: _____
Recreational drug use: ☐ No ☐ Yes Type: _____ Frequency: _____
Coffee: ☐ No ☐ Yes Cups per day: _____
Tea: ☐ No ☐ Yes Cups per day: _____
Sodas: ☐ No ☐ Yes Cans per day: _____ Type: _____
Chocolate: ☐ No ☐ Yes How often: _____

Exercise: ☐ No ☐ Yes Type: _____ Frequency: _____ Duration: _____
How much time do you spend outside per day? _____
Do you wear sunglasses, contact lenses, or glasses when outside? (circle one or more)
Do you have annual eye examinations? ☐ No ☐ Yes
Do you see a dentist regularly? ☐ No ☐ Yes How often? _____
Average hours of sleep per night: _____ Is your sleep interrupted? ☐ No ☐ Yes
Time you typically go to bed: _____ Time you usually arise: _____
Do you feel well rested and ready to go in the morning? ☐ No ☐ Yes
Please rate the quality of your sleep (1 = poor and 10 = great): _____

Do you perspire when you exercise? ☐ Lightly ☐ Moderately ☐ Heavily
Do you perspire other than when exercising? ☐ No ☐ At times ☐ Yes
Do you have difficulty perspiring? ☐ No ☐ Yes
Does your perspiration smell strong? ☐ No ☐ Yes
Are you ever exposed to toxic fumes or chemicals (at work or at home): ☐ No ☐ Yes
Are you exposed to second hand smoke? ☐ No ☐ Yes
Do you have house pets? ☐ No ☐ Yes
What techniques or practices do you use to manage stress? _____

_____

Please list the most significant, stressful events in your life (from the most recent to the most distant)
Indicate situations that are continuing to impact your life with an asterisk [*]:

_____

_____

_____

Are you satisfied with your sexual experience? ☐ No ☐ Yes

DIETARY INFORMATION

Do you skip meals? ☐ No ☐ Yes

_____

Do you eat breakfast? ☐ No ☐ Yes ☐ At times What time: _____
Describe last breakfast in detail: _____

Do you eat lunch? ☐ No ☐ Yes ☐ At times What time: _____
Describe last lunch in detail: _____

Do you eat dinner? ☐ No ☐ Yes ☐ At times What time: _____
Describe last dinner in detail: _____

Do you snack? ☐ No ☐ Yes ☐ At times What time(s): _____
Describe your snack choices: _____

What foods do you eat everyday? _____
What foods do you crave? _____
What foods cause you problems? _____
Are you on a special diet? ☐ No ☐ Yes Describe: _____
Do you diet often? ☐ No ☐ Yes
Do you eat at fast food restaurants? ☐ No ☐ Yes How often: _____
Do you eat out at restaurants a lot? ☐ No ☐ Yes How often: _____
Do you use NutriSweet (aspartame) or other artificial sweeteners? ☐ No ☐ Yes ☐ At times
How much water do you drink on average per day? _____
Have you traveled to a third world country? ☐ No ☐ Yes Date: _____Place: _____

OTHER INFORMATION

Is there anything else you would like the doctor to know about you?