Manhattan Advanced Medicine
A PATH TO WELLNESS

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Health History

Name: _____Today's date: _____

Age: _____ DOB: _____ Date last physical: _____

Main reason for your visit – describe your chief complaint:

_____

_____

History of present illness - give a brief summary of your main condition(s) (how long ill, when diagnosed, main/worst symptoms):

_____

_____

_____

Past medical history - list all major medical diagnoses you have had:

_____

_____

_____

Past surgical history - list all major surgeries you have had:

_____

_____

_____

Consultations - list all specialists you have seen for your main issue/diagnosis, type of MD (not their name), tests they performed or ordered, their diagnosis/treatment plan and your response to treatment:

Example: Neurology, Rheumatology, Pulmonary, Endocrinology, Cardiology, ENT, Allergy, Gastroenterology, Orthopedic, Pain Mgmt, Psych, Urology, Hematology, Dermatology, I.D., LLMD, N.D., Homeopath, etc.

_____

_____

_____

Other practitioners – list other practitioners you have seen (ex; acupuncture, chiropractor, massage) and response:

_____

_____

Patient name: _____**Today's date:** _____

Special studies – list all special tests you have had and results not mentioned above:
Example: MRI or CT scan (brain, spine, chest, abdomen, pelvis), ultrasounds (sonograms – thyroid, abdomen, pelvis, etc), CXR, EKG, Holter, Cardiac Echo, Stress Test, Tilt Table Test, Sleep Study, EEG, Colonoscopy or Upper Scoping (EGD), PFT's, Rhinoscopy, Cystoscopy, Biopsy (skin, thyroid, bone marrow, etc), special labs, stool studies, etc.

_____

_____

_____

_____

Prescribed meds currently on:

_____

_____

Meds tried in past for main conditions & effect:

_____

_____

Allergies (meds, food, etc):

_____

_____

OTC (over the counter meds) and supplements currently taking:

_____

_____

Family history - list all major medical diagnoses of the following relatives (parents, aunts, uncles, grandparents, siblings):

_____

_____

_____

_____

Health habits - caffeine use / smoking / alcohol / drugs:

_____

_____

Diet/exercise/sleep habits:

_____

_____

Patient name: _____Today's date: _____

Review of systems

Please circle all that apply.

General

Headache Lethargy/weakness Chills/night sweats Fever Dizziness Fatigue
Fainting spells/unconsciousness Weight loss/gain Numbness Cold extremities

Eyes

Wear glasses Eyesight worsening Double vision Eye pain Floaters Flashes
Light sensitivity

Ear/nose/throat

Deafness Noise/ringing in ears Congestion/sneezing Sinus trouble/hay fever
Nose bleeds Sore throat or tongue Hoarse voice Dental problem Earache
Bleeding gums Chronic cough

Heart

Chest pain/pressure/tightness/squeezing Heart racing/palpitations Heart attack
Heart murmur Irregular heart beat Mitral valve prolapsed Swollen feet/ankles
High / low blood pressure Heart valve replacement Atrial fibrillation
Poor circulation POTS

Lung

Lung cancer Shortness of breath Chest pain Pneumonia Coughing up phlegm
Cough up blood Wheezing/cough

Gastrointestinal

Trouble swallowing Heartburn/indigestion Change in bowel habits Vomiting blood
Loose Stool/diarrhea Black/Bloody Stools Frequent stomach pain Constipation
Irritable bowel Ulcers Stomach/bowel cancer Excessive gas or bloating Nausea
Rectal bleed Black stool Excessive hunger or thirst Poor appetite Feeling full fast

Kidney/Prostate

Frequent voiding Burning on urination Pus/blood in urine Trouble starting urination
Dribble with cough/sneeze Loss of urine control Prostate disease/cancer
Sexual difficulty

Patient name: _____Today's date: _____

Review of systems (cont.)

Please circle all that apply.

Skin

Rashes Birthmarks Sores Dry/oily skin Hair growth/loss Bruise easily Hives
Itching Scars Nonhealing sores Discharge from skin "Fibers" coming out of skin

Muscle/bone

Back pain Neck pain Back surgery Arthritis Fibromyalgia Aching muscle/joints
Shoe lift or brace Bone/joint injury Osteoporosis Muscle spasms or twitches

Hematologic

Blood disease Enlarged glands Bleed/bruise easily Anemia/low blood

Neurological

Stroke Seizures Head injury/concussion Memory loss/fog Trouble speaking
Confusion Trouble swallowing Unsteady gait Trouble walking Arm/leg weakness
Tingling or numbness

Psychiatric

Nervous breakdown Panic attacks Cry often/depressed Worry Considered suicide
Loss of interest in eating Anxiety/tension/nervousness Loss of energy/fatigue

Endocrine

Unwanted weight change Breast discharge Excessive thirst Excessive tiredness
Swollen glands or thyroid Thyroid cysts/overactive/underactive Diabetes
Adrenal or pituitary issue

Women only

Endometriosis Currently pregnant Irregular menstrual period Breast discharge
Lumps in breast Abnormal PAP Painful intercourse Hot flashes
Excessive bleeding Severe menses
Last Menstrual Period _____ Last PAP _____ Last Mammo _____

Men only

Lump in testicles Penis discharge Sore on penis Erection difficulties Breast lump

Patient name: _____Today's date: _____

Review of systems (cont.)

Please circle all that apply.

Sleep

Dreams/sleep walk Legs twitch Insomnia Daytime drowsiness Snores

Breath holding/gasping Restless sleep Sleep nonrestorative (wake exhausted)

No dream recall Frequent awakening during night

# of hours sleep per night_____ # of continuous hours sleep per night_____

# of hours you would like to sleep_____ #of hours sleep needed to feel rested_____

Environmental exposure

Toxins Mold Chemicals in the home Other

Other conditions now or in past

Alcoholism Chemical dependency Cataracts Macular degeneration Glaucoma

Chicken pox Diabetes Goiter Gout Hepatitis Herpes High cholesterol

HIV positive Kidney/liver/heart disease Migraines Mono Pacemaker Polio

Stroke TB Recurrent tonsillitis Recurrent sinusitis Venereal disease

Other

_____

_____

_____

_____

_____