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www.SelfCenter.com

SELF CENTER, P.C.

MEDICAL HISTORY

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All information is treated as confidential. **Please print or type and complete all information.**

Today's Date	Birthdate	Male ☐ Female ☐	Social Security #	Drivers License #

Last Name First Middle	Daytime Phone ( )	Home Phone ( )	Cell Phone ( )

Address City State Zip	Occupation	E-mail	Marital Status M S W D

Spouse Name	Birthdate	Social Security #	Spouse Occupation

Last Physical Exam Date	By What Physician	Phone # ( )	Family Physician	Phone # ( )

Family History	If Living Health Age	Good	Fair	Poor	If Deceased Death Age	Death Cause
Father						
Mother						
Brothers Sisters (Circle Sex)						
1. M F						
2. M F						
3. M F						
4. M F						
5. M F						
Husband ☐						
Wife ☐						
Sons Daughters (Circle Sex)						
1. M F						
2. M F						
3. M F						
4. M F						
5. M F						

Any blood relatives who have, or have had, any of the listed conditions

	Yes	No	Relationship		Yes	No	Relationship
Alcoholism				Insanity			
Cancer				Kidney Disease			
Congenital Heart				Leukemia			
Diabetes				Migraine			
Drug Abuse				Nervous Break'n			
Epilepsy				Obesity			
Goiter				Stroke			
High Bl.Press.				Suicide			
Heart Disease				Stomach Ulcers			

Do you now smoke? _____ **How many per day?** _____

How long ago did you stop smoking? _____

Habits

Do you	Circle		Daily Consumption
Smoke	Yes	No	_____ Pkgs.
Drink Coffee	Yes	No	_____ Cups
Drink Alcohol	Yes	No	_____ oz.
Drink Beer	Yes	No	_____ oz.
Fall Asleep Easily	Yes	No	
Awaken Early	Yes	No	

Diseases you have had requiring hospitalization	Year

Serious illness not requiring hospitalization	Year

What Medicines are you allergic to:

	Circle		Operations you have had:
Gallbladder Surgery	Yes	No	Others (list)
Hysterectomy . .	Yes	No	
Oophorectomy . .	Yes	No	
Tubal Ligation . .	Yes	No	

List all Prescribed Medication or over the counter drugs that you are taking:

Name of Medication:	Amount:	Frequency:

Have you ever had shortness of breath?

	Circle	
Doing your usual work?	Yes	No
Climbing a flight of stairs? . . .	Yes	No
Which awakens you at night? . .	Yes	No
Do you have a chronic cough? . .	Yes	No
Accompanied by wheezing? . .	Yes	No
Have you ever coughed blood? .	Yes	No
Do you cough up much sputum? .	Yes	No

Have you had pain or tightness in the chest which begins:

	Circle			Circle	
When exerting yourself? . . .	Yes	No	Radiates down the arm?	Yes	No
When walking up a hill? . . .	Yes	No	Disappears if you rest?	Yes	No
After a heavy meal?	Yes	No	Occurs only at rest?	Yes	No
When upset or excited? . . .	Yes	No	When walking fast?	Yes	No
Palpitations?	Yes	No	When walking in cold weather? . .	Yes	No
Heart rhythm problems? . . .	Yes	No	If you have chest pain or tightness please explain		

Please complete front and back of this form

Women only:	**Circle**	
Are you pregnant?	Yes	No
Are you nursing an infant?	Yes	No
Are you post menopausal?	Yes	No
Are you still having regular monthly menstrual periods?	Yes	No
Do you feel bloated and irritable before your period?	Yes	No
Are you now on or have you ever taken the birth control pills?	Yes	No
Date of last menstrual period _____		
How many cesarean operations?	Yes	No

Men only:	**Circle**	
Have you ever had:		
Loss of sexual activity? For how long?_____	Yes	No
Impotence?	Yes	No
Sexual Problems, other?	Yes	No
Prostate trouble?	Yes	No

Have you had or do you have:	**Circle**	
Glaucoma (narrow-angle)?	Yes	No
Glaucoma(open-angle)?	Yes	No
Medicine or treatment for above glaucoma?	Yes	No
Kidney/Renal dysfunction?	Yes	No
Emphysema?	Yes	No

Have you had or do you have:	**Circle**		**When or since when?**
A nervous problem?	Yes	No	
Alcohol problem?	Yes	No	
Drug problem?	Yes	No	
Treatment in an alcohol or drug abuse program?	Yes	No	
A depression episode?	Yes	No	
Any treatment for depression including medicines, counseling, in or out patient treatment?	Yes	No	
Any manic episodes?	Yes	No	
Any psychiactric diagnosis or psychological diagnosis?	Yes	No	
Suicidal thoughts or attemps?	Yes	No	
A convulsion/seizure?	Yes	No	
An abnormal electrocardiogram?	Yes	No	
Mitral Valve Prolapse?	Yes	No	

Current History

	Check if positive			Check if positive	
Frequent headaches			Frequent diarrhea		
Dizziness			Irregular periods		
Fainting spells			No periods		
Convulsions			Painful periods		
Hard of hearing			Vaginal discharge		
Change in vision			Pregnancies (how many)		
Dental problems			Dry skin		
Difficulty swallowing			Feel cold alot		
Shortness of breath			Tiredness		
Wheezing			Blood in urine		
Skipping irregular heart			Painful urination		
Chest pains			Kidney Stones		
Indigestion			Joint pains		
Heartburn			Back trouble		
Chronic stomach pains			Hairloss		
Constipation			Other		

Past History

	Check if positive	
Pneumonia		
Tuberculosis		
Heart Attack		
Heart Failure		
Angina		
Rheumatic Fever		
Veneral Disease		
Kidney Trouble		
Diabetes age of onset		
Gout		
Stomach or duodenal ulcer		
Bowel Disease		
Psychiatric illness		
Drinking Problem		
Other		

May we contact you about appointments, new procedures or new information at the Self Center?
Via e-mail? Yes No
Via text message? Yes No

Your Age _____ **years**

Height _____ **ft.** _____ **in. or** _____ **cm.**

Weight _____ **lbs.or** _____ **kg.**

How much weight do you wish to lose? _____ **lbs.**

Insured Full Name: _____

Primary Insurance Company: _____ **Contract Number:** _____
Address: _____
City: _____ **State:** ___ **Zip:** _____ **Group Number:** _____
Phone #: _____

Secondary Insurance Company: _____ **Contract Number:** _____
Address: _____
City: _____ **State:** ___ **Zip:** _____ **Group Number:** _____
Phone #: _____

I certify that the information above is truthful and accurate to the best of my knowledge.

_____ Signature _____ Date

How did you hear about our Center? _____

Who referred you? _____

Address: _____