MARANATHA MEDICAL PLAZA

Medical History DATE: _____/_____/_____
PLEASE FAX BACK TO 229-245-7661 OR HAND CARRY TO YOUR APPOINTMENT. DO NOT MAIL.

Name ____
(Last) (First) (Middle)
Home Address
____
(Street) (City) (State) (Zip)
Home Phone (____) _____________________
Business Phone (____) ______________________ Ext. ____________
Cell Phone (____) _______________________
Email Address ____
Employer ____
Occupation________________________________
Age ______ DOB _________ Place of Birth _____________________ Education (highest level attained) ____________
Personal Physician _________________________
Address ____
(Street) (City) (State) (Zip)
CURRENT SYMPTOMS OR PROBLEMS you would like evaluated?

1. ____
2. ____
3. ____
4. ____

KNOWN MEDICAL CONDITIONS YOU HAVE OR ARE BEING TREATED FOR:

1. ____
2. ____
3. ____
4. ____

PREVIOUS HOSPITALIZATIONS/OPERATIONS:

1. _________________________________Date: __________
2. _________________________________Date: __________
3. _________________________________Date: __________
4. _________________________________Date: __________

PRIOR SERIOUS ILLNESS, INJURIES AND BROKEN BONES:

1. _________________________________Date: __________
2. _________________________________Date: __________
3. _________________________________Date: __________
4. _________________________________Date: __________

MEDICATIONS: List all prescription medicines that you have been taking recently. Please bring ALL medicines with you.
Name, dose (strength & times per day) and date started

1. ____
2. ____
3. ____
4. ____
5 ____
6. ____
7 . ____
8 . ____

List all non-prescription medications, vitamins, and supplements you are taking:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Do you take aspirin or over-the-counter pain medication? Yes _________ No _________
If so, what drug and frequency ____
ALLERGIES or reactions to medicines or other substances. Name of Medication and Type of Reaction:

1. ____
2. ____
3. ____
4. ____

IMMUNIZATION HISTORY (bring records with you) Vaccine Date
Tetanus/Diphtheria _____________________________
Pneumococcal _____________________________
Hepatitis A _____________________________
Hepatitis B _____________________________
Influenza _____________________________
Herpes Zoster (Shingles) _____________________________
Other _____________________________
FAMILY HISTORY: List parents, all natural brothers and sisters, and children. If deceased, list age at death.
Living Age(s) Known serious medical conditions or cause of death
Mother ☐ Yes ☐ No _______________________________
____
Father ☐ Yes ☐ No _______________________________
____
Sisters ☐ Yes ☐ No _______________________________
____
Brothers ☐ Yes ☐ No _______________________________
____
Children ☐ Yes ☐ No _______________________________
____
Spouse ☐ Yes ☐ No _______________________________
____
Is there a family history of any of the following in a blood relative, including parents, sisters, brothers, grandparents, aunts, uncles, etc.?

☐ Stroke ☐ Emphysema ☐ Thyroid Disease
☐ Heart Attack/Angioplasty/Heart Surgery ☐ Glaucoma ☐ Kidney Disease
☐ Blood Pressure ☐ Arthritis ☐ Osteoporosis
☐ High Cholesterol/Triglycerides ☐ Liver Disease ☐ Mental Health Disease
☐ Diabetes ☐ Colon Cancer ☐ Alcoholism
☐ Brain Aneurysm ☐ Colon Polyps ☐ Migraine Headaches
☐ Aortic Aneurysm ☐ Breast Cancer ☐ Epilepsy (Seizures)
☐ Tuberculosis ☐ Other Cancer ☐ Other Problems:
☐ Asthma type _________________________ ______________________

GENERAL

Yes No

- ☐ ☐ Have you had skin disease or skin cancer?
- ☐ ☐ Do you have any lumps in your skin of concern to you?
- ☐ ☐ Are any moles getting larger or changing color?
- ☐ ☐ Do you have any problem with skin rashes?
- ☐ ☐ Have you had recent fever, chills or night sweats?

HEAD AND NECK

Yes No

- ☐ ☐ Do you have frequent or periodic headaches?
- ☐ ☐ Does your vision blur, do you see double or do you see haloes around lights?
- ☐ ☐ Have you or your family noticed your hearing has changed?
- ☐ ☐ Do you have ringing in the ears?
- ☐ ☐ Do you wear a hearing aid?
- ☐ ☐ Do you lose your balance or fall?
- ☐ ☐ Have you had or been treated for vertigo?
- ☐ ☐ Are you often hoarse?
- ☐ ☐ Do you have sinus trouble? If so, at any particular time of the year _____________________

GASTROINTESTINAL

Yes No

- ☐ ☐ Have you had trouble swallowing?
- ☐ ☐ Do you have heartburn?
- ☐ ☐ Have you ever had an ulcer? If so, when ________________________
- ☐ ☐ Are you bothered with recurrent abdominal pain?
  If yes, upper _________ lower ___________ right ___________ left _________
- ☐ ☐ Have you had hepatitis or abnormal liver tests?
- ☐ ☐ Have you had a recent change in bowel habits or problems with diarrhea or constipation?
- ☐ ☐ Have you had black or tarry appearing stools?
- ☐ ☐ Have you had a polyp or cancer in your colon or rectum?
- ☐ ☐ Have you had rectal bleeding, blood with your stool, or blood on toilet paper?
- ☐ ☐ Do you have hemorrhoids?
- ☐ ☐ Has anyone in your family had cancer of the colon? If yes, specify family member(s) and at what age they were diagnosed ____

Date, place and result of your most recent proctosigmoidoscopy or colonoscopy

____

____

MUSCULOSKELETAL

Yes No

- ☐ ☐ Have you had back pain? If so, does it go down into the buttock, thigh, calf or foot? Yes ___ No ___
- ☐ ☐ Have you had joint pain? If so, which joint? _____________________________________
- ☐ ☐ Do you have muscle pain? If so, where? ____
- ☐ ☐ Do you have excessive muscle tension? If yes, when? _______________________________
- ☐ ☐ Do you have neck pain? When ____
- ☐ ☐ Have you had fractures as an adult?

MISCELLANEOUS

Yes No

- ☐ ☐ Have you had seizures or convulsions as an adult? If so, when? ___________________
- ☐ ☐ Have you had anemia?
- ☐ ☐ Have you had unusual bleeding or bruising?
- ☐ ☐ Have you ever had a blood transfusion? If so, when? ________________
- ☐ ☐ Have you had significant stress recently?
- ☐ ☐ Have you had significant anger recently?

□ □ Have you had significant sadness or depression recently?
□ □ Have you had a problem with sleep? If yes:
a. Problem falling asleep? Yes ____ No ____
b. Problem awakening mid sleep? Yes _____ No _____
c. Problem in early morning awakening and not able to return to sleep? Yes _____ No _____
□ □ Do you take medication or supplements for sleep? If yes, what and how often ______________________
□ □ Do you snore heavily?
□ □ Have you been observed to stop breathing when sleeping?
□ □ Are you frequently tired or fatigued?
□ □ Are you frequently nervous or anxious?
□ □ Are you frequently irritable or short tempered?
□ □ Major life change events in the past year?
□ □Have family members experienced major stress in the past few years?
□ □ Have you had significant loss of friends or family in the past few years?
□ □ Have you ever needed professional help for alcohol, drugs or mental health?
□ □ Do you smoke now? If so:
________ packs of cigarettes/day or week
________ cigars/day or week _________ (pipe) pouches/day or week
________ total years smoking
□ □ Did you smoke previously? If so:
When did you quit? ________________ Packs/day _______________ Total years smoking ____________
□ □ Do you were a seatbelt whenever in the car?
□ □ Do you consume alcohol? If so:
Liquor __________ drinks/day or week (1 drink = 1.5 oz liquor)
Wine __________ glasses/day or week (1 glass wine = 5 oz wine)
Beer __________ bottles or glasses/day or week (1 bottle or glass beer = 12 oz)
□ □ Do you drink coffee? If so:
caffeinated ______ cups/day decaffeinated _______ cups/day
□ □ Do you drink caffeinated soda? If so:
______ ounces/day Diet _______ or Regular _______

FOR FEMALES ONLY

Yes No
□ □ Do you have any vaginal problems or symptoms?
□ □ Do you have any breast tenderness or nipple discharge?
□ □ If having menstrual periods, have they changed recently?
How many days are in your menstrual cycle? _______________
How many days do you flow? ______________
How many pads or tampons do you use on the heaviest day of the flow? ______________
Age of onset of menstrual periods _______________
□ □ Is premenstrual tension a problem for you?
□ □ If postmenopausal, are you having vaginal spotting or bleeding?
□ □ Are you having problems with hot flashes?
□ □ Do you have concern about physical or emotional abuse?
Date of last menstrual period _________________
Date of last mammogram ____________________ Result __________________________________
Date of last Pap smear ______________________ Result ___________________________________
Date of last bone density _____________________ Result __________________________________
Age at first full term pregnancy _________________ Number of live births ____________________

NUTRITION

Have you ever been diagnosed with:

Yes No
□ □ High blood pressure
□ □ Reflux (heartburn)

□ □ Lactose intolerance
□ □ High blood sugars
□ □ Diabetes
□ □ High cholesterol
□ □ Low good cholesterol (HDL)
□ □ High triglycerides
Other nutrition-related condition: ____
□ □ Are you at a weight that you want to be? If no, what do you think would be a healthy, realistic weight for you? _____________ lbs.
How has your weight changed over the past year? No change _______ # gain _______ # lost _______
What weight loss diets or programs have you tried in the past?
Atkins _____ South Beach _____ Weight Watchers _____ Jenny Craig _____ Other _____
On a scale of 0-10 with 0 being the least motivated and 10 being the most motivated, how would you rate your current motivation to make diet changes? ______
What is your #1 nutrition/diet concern and how can the dietician help you meet your need?
____
____
Who does the majority of cooking for your family? You _____ Spouse _____ Other _____
Who does the majority of the grocery shopping for your family? You _____ Spouse _____ Other _____
Average number of meals (breakfast, lunch, and dinner) in restaurants, cafeterias, catered or social functions:
_____ 0-3 times per week
_____ 4-6 times per week
_____ 7+ times per week
Do you add salt to your foods? Never-Rarely _____ Occasionally _____ Often _____
Foods you consume on a regular basis:
□ deli and cured meats □ cheese □ non homemade soups □ frozen foods
□ chips □ boxed rice □ noodle mixes
Do you typically skip meals? Yes _____ No _____ If yes, which meal? ____________________________
Do you read food labels? Never-Rarely _____ Occasionally _____ Often _____
Do you choose reduced fat or fat-free products when available? Never-Rarely _____ Occasionally _____ Often _____
Do you eat doughnuts, croissants, muffins, or sweet rolls? Never-Rarely _____ Occasionally _____ Often _____
Please choose those you consume on a regular basis:
□ fried foods □ regular salad dressing □ regular cheese
□ butter □ oil □ peanut butter
□ margarine □ gravy □ cream sauces
How many servings do you have from the dairy group/day? _________________
(A serving is 8 oz milk/yogurt or soy milk, ½ cup cottage cheese, 1 oz cheese, 1 cup yogurt)
How many servings do you have from the vegetable group/day? ________________
(A serving is 2 cups salad, ½ cup cooked vegetables, 1 cup raw vegetables or 6 oz vegetable juice)
How many servings of fruit do you eat/day? _____________
(A serving is 1 piece fruit, 6 oz juice, 2 tablespoons raisins, 1 cup fresh fruit, ½ cup canned fruit)
Do you eat **whole** grains daily? (A serving is 1 slice whole grain bread, ½ cup brown or wild rice, ½ cup whole grain pasta, ¾
cup cereal with at least 5 grams of fiber, popcorn, etc)
Yes ____ If yes, number of servings per day _____
No ____
Do you drink **regular** soda/pop, sweetened iced tea, sports drinks, or other sweetened beverages?
Yes _____ If yes, ounces per day __________
No _____
How many times **per week** do you eat: fish _______ red meat (including pork) ______
How many glasses of water do you drink per day? ___________

EXERCISE/ACTIVITY

Yes No
□ □ Do you have a regular exercise program? If so, what activity and frequency?
Cardiovascular Type ____
Frequency ____________________________ times/week
Duration ______________________________ minutes
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Strength Type ____
Frequency ____________________________ times/week
Duration ______________________________minutes
Flexibility Type ____
Frequency ____________________________ times/week
Duration ______________________________minutes
Sport Type ____
Frequency ____________________________ times/week
Duration ______________________________minutes
How many steps can you walk up before becoming winded? __________________
What level of activity do you have at work? Sedentary _____ Somewhat Active _____ Active _____
Very Active _____
Yes No
□ □ Do you have any exercise equipment available to you?
If so, what? ____

WORK

Number of work hrs. / week ____________________
Percent of time you travel ________________% Travel to Third World countries? Yes ____ No ____
Do you feel you manage stress effectively? No _____ Most of the time _____ Yes _____
External stress level at work: Mild _____ Moderate _____ Heavy _____ Very Heavy _____
Internal stress level: Mild _____ Moderate _____ Heavy _____ Very Heavy _____
What do you do for stress reduction?
____
Yes No
□ □ Are you considering retirement in the next year?
□ □ Are you considering retirement sometime in the near future?

List any other health issues or symptoms you wish to discuss or address:
____
____
____