RescuingHealth

NAME:_____PREFERRED NAME:_____

PRONOUNS:_____DOB:_____Today's Date:_____

Personal History: **Please circle if you have any history of the following:**				**Family History:** **Note Relative and Age of Onset:**
Seasonal Allergies	Food Allergies	Allergy Shots	Arrhythmia	Heart Attack, Bypass Surgery
High Cholesterol	Heart Attack	Coronary Artery Disease	Stroke	High Blood Pressure
High Blood Pressure	Mitral Valve Prolapse	Deep Vein Thrombosis (Clot)	Tuberculosis	Stroke
Asthma	Sleep Apnea	COPD (Emphysema)	Irritable Bowel Syndrom	Clotting Disorders (DVT, Pulmonary Embolus)
Appendicitis	Reflux/Heartburn	Hepatitis	Peptic Ulcer Diesase	Diabetes
Inflammatory Bowel Disease	Ulcerative Colitis	Chron's Disease	Lung Cancer	Tyroid Disorders
Kidney Stones	Impotence	Diabetes (High Sugars)	Anxiety	Cancers
Thyroid Disease	Prior Blood Transfusions	Breast Cancer	Depression	Any other illnesses:
Anemia	Seizures or Epilepsy	Migraines	Osteoporosis	
Cancer of any type	Osteoarthritis	Osteopenia		
ADD	Substance Abuse	Any other illnesses:		
ADHD				
Rheumatoid Arthritis				
Alcoholism				

Details:

How did you hear about Rescuing Health?

_____

_____

Previous Surgeries: List what type of surgery and when it occurred.

_____

_____

_____

Medication:

Medication	Dose	Reason

Allergies:

Allergy	Reaction
☐ I have no known drug allergies	

Social History and Screening Questions:

Any history of the following?		**Home Life**		**Screening Test**	**When?**
Tobacco use (list type and amount):		**Occupation**		**Last Flu Vacc:**	
Alcohol use (list type and amount):		**Church Affiliation**		**Last Tetanus Vacc:**	
Recreational drug use:		**Marital Status**		**Pneumonia Vacc:**	
Sexually Transmitted Diseases:		**Children (Names/ages):**		**Colonoscopy:**	
HIV or AIDS:				**Dexa Scan:**	
Seat belt/car seat use:				**Stress Test:**	
Children with access to firearms:				**Mammogram:**	
Regular Exercise:				**Pap smear (list if abnormal):**	
Brush and floss daily:					
Dietary habits:					

Does anyone in your household smoke?	Yes	No
Do you do monthly breasts or testicular self-exams?	Yes	No

Have you been in a situation where you felt you were being hurt? (Including physical abuse such as hitting, kicking as well as emotional and sexual abuse)	Yes No

In the last two weeks have you had any of the following: (Please circle all that apply)

General	Fever or chills	Excessive nighttime sweating	Weight gain or loss	Headaches
Eyes	Double vision	Flashing Lights	Loss of vision	
Ears, Nose, Throat	Nasal congestion	Nasal discharge	Sore throat	Difficulty swallowing
Breasts	Discharge from breast	Skin changes	Pain in breast	
Cardiovascular	Chest pain	Rapid heart rate	Pounding heart beats	Swelling of legs
	Difficulty breathing while laying down	Smothering sensation after going to sleep	Lightheadedness	
Respiratory	Shortness of breath	Coughing	wheezing	Coughing up blood
Gastrointestinal	nausea	vomiting	diarrhea	Constipation
	Blood in stools	Black, tarry stools	Abdominal pain	Changing appetite
Genitourinary	Burning with urination	Blood in urine	Frequent urination	Incontinence
	Change in menstrual habits	Vaginal discharge	Penile discharge	Pain in scrotum
Skin	New rash	Change in skin lesions	acne	Itching
Neurological	weakness	incoordination	Loss of consciousness	Seizures
Musculoskeletal	Joint pain	Joint swelling	Muscle weakness	
Endocrine	Frequent nighttime urination	Excessive food and water intake	Heat or cold intolerance	Loss of sexual desire
Psychiatric	Lost interest in hobbies	anxiety	depression	Behavior problems
	hallucinations	Feeling confused	Impulsive behavior	Thoughts of suicide
Hematological	Easy bleeding/bruising	Swollen lymph nodes		
Immunological	Allergic sinus problems	Allergic skin problems	Frequent illnesses	