

# The Preventive Medicine Center of Gainesville, Inc.

## HEALTH PROFILE

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Chart # \_\_\_\_\_

DEAR PATIENT: Welcome. Our goal is simple. We wish to provide you and your family with quality health care and personal attention. Before you see Dr. Erickson, we want you to take a very important first step by letting him know something about yourself and your health. *We'd like you to fill out and return this Health Profile to us.* You may also receive a Nutritional Symptom Profile to fill out. This is an important first step we take with all new patients, and it allows Dr. Erickson to advise you on how to avoid specific health threats and heal problems you may be dealing with now. We take these Health Profiles very seriously! This is a confidential record and will be kept in this office.

Birth date _____ Place of birth _____ Highest level in school _____ Occupation _____ Marital Status _____ Hobbies _____ Habits: Smoking (type & amount) _____ If former smoker, date quit _____ Alcohol (type & amount per week) _____ Caffeine (type & amount per day) _____ Street drugs (type & amount per day) _____ Average hours of sleep/night _____ Bowel movements per week _____ Usual weight _____ Exercise level: <input type="checkbox"/> rare <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> 4 or more times Please list all Allergies (foods, drugs, environment) _____ _____ _____ <b>Chief Complaints:</b> Please list in order of importance to you the 3 pressing health concerns, symptoms or problems you are experiencing: 1. _____ _____ 2. _____ _____ 3. _____ _____	When was your last physical exam? _____ Who is your current primary care doctor? _____ Please list all hospitalizations/and or serious illness you have had and the year when these occurred: <input type="checkbox"/> none _____ _____ Do you use magnets or sleep on a magnetic mattress? _____ Are you a vegetarian? _____ List all prescription drugs you are currently taking and how many: <input type="checkbox"/> none _____ _____ Do you currently take a multivitamin? <input type="checkbox"/> yes <input type="checkbox"/> no How many multivitamin pills or capsules do you take daily? _____ Other than a multivitamin, are you taking (please $\checkmark$ all that apply): <input type="checkbox"/> Vitamin C <input type="checkbox"/> CoEnzyme Q10 <input type="checkbox"/> Magnesium <input type="checkbox"/> Vitamin E <input type="checkbox"/> B-Complex <input type="checkbox"/> Ginseng <input type="checkbox"/> Calcium <input type="checkbox"/> Beta Carotene <input type="checkbox"/> L-Carnitine <input type="checkbox"/> Garlic <input type="checkbox"/> Gingko Biloba <input type="checkbox"/> Saw Palmetto <input type="checkbox"/> DHEA <input type="checkbox"/> Melatonin <input type="checkbox"/> Glucosamine Sulfate <input type="checkbox"/> Chromium Picolinate      Other: _____ Date of last dental exam _____ Do you have amalgams (silver fillings)? <input type="checkbox"/> yes <input type="checkbox"/> no Have you had your amalgams removed? <input type="checkbox"/> yes <input type="checkbox"/> no <span style="float: right;">When? _____</span>
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**Past Medical History:** ✓ Box  if you have ever had any of the following.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Measles            | <input type="checkbox"/> Tuberculosis                 | <input type="checkbox"/> Kidney Disease                   |
| <input type="checkbox"/> Mumps              | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Thyroid Disease                  |
| <input type="checkbox"/> Chickenpox         | <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Bleeding tendency                |
| <input type="checkbox"/> Whooping Cough     | <input type="checkbox"/> Polio                        | <input type="checkbox"/> Asthma                           |
| <input type="checkbox"/> Scarlet Fever      | <input type="checkbox"/> Glaucoma                     | <input type="checkbox"/> Depression                       |
| <input type="checkbox"/> Diphtheria         | <input type="checkbox"/> Hernia                       | <input type="checkbox"/> Mental Illness                   |
| <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Blood or plasma transfusions | <input type="checkbox"/> Drug or alcohol problem          |
| <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Back trouble                 | <input type="checkbox"/> Any other disease (please list): |
| <input type="checkbox"/> Heart Disease      | <input type="checkbox"/> High or low blood pressure   | _____   |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Hives or Eczema              | _____   |
| <input type="checkbox"/> Venereal Disease   | <input type="checkbox"/> AIDS or HIV +                | _____   |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Mitral Valve Prolapse        | _____   |
| <input type="checkbox"/> Bladder Infections | <input type="checkbox"/> Stroke                       | _____   |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> Hepatitis                    |   |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Bleeding Ulcer               |   |

**Family History:** Have your parents, grandparents, siblings or children had any of the following:

- |  | Relationship |   | Relationship |
|--|--------------|---|--------------|
| <input type="checkbox"/> Cancer              | _____        | <input type="checkbox"/> Stroke               | _____        |
| <input type="checkbox"/> Tuberculosis        | _____        | <input type="checkbox"/> Epilepsy             | _____        |
| <input type="checkbox"/> Heart Disease       | _____        | <input type="checkbox"/> Bleeding tendency    | _____        |
| <input type="checkbox"/> High Blood Pressure | _____        | <input type="checkbox"/> Asthma               | _____        |
| <input type="checkbox"/> Obesity             | _____        | <input type="checkbox"/> Drug/alcohol problem | _____        |
| <input type="checkbox"/> Thyroid Disease     | _____        | <input type="checkbox"/> Mental illness       | _____        |
| <input type="checkbox"/> Diabetes            | _____        | <input type="checkbox"/> Leukemia             | _____        |
| <input type="checkbox"/> High Cholesterol    | _____        | <input type="checkbox"/> Gout                 | _____        |
| <input type="checkbox"/> Kidney Disease      | _____        | <input type="checkbox"/> Migraine Headaches   | _____        |

Present Age and Condition/Diseases	Age at Death and Cause/Diseases
Father:	
Mother:	
Siblings:	
Spouse:	
Children:	

**Do you now have or have you had within the past year any of the following (Circle “no” or “yes”. If uncertain, leave blank.):**

**General:**

Weakness or paralysis.....no	yes	Change in appetite.....no	yes	Night sweats.....no	yes
Tire easily/fatigue.....no	yes	Sensitivity to cold or heat.....no	yes	Brain fog.....no	yes
Recent weight changes.....no	yes	Persistent fever.....no	yes		

**Skin:**

Skin rash.....no	yes	Skin dry.....no	yes	Change in color of mole.....no	yes
Hair falling out.....no	yes	Split/brittle nails.....no	yes		

**HEENT:**

Gums bleed.....no	yes	Wear glasses or contacts.....no	yes	Blurred vision.....no	yes
Decrease in hearing.....no	yes	Frequent nosebleeds.....no	yes	ringing in ears.....no	yes
Loss of smell.....no	yes	Persistent hoarseness.....no	yes	Sinus trouble.....no	yes
Sore tongue or gums.....no	yes	Bad breath.....no	yes	Sore throat.....no	yes

**Respiratory-cardiovascular:**

Lump in breast.....no	yes	Chronic or frequent cough.....no	yes	Shortness of breath.....no	yes
Breast discharge.....no	yes	Wheezing.....no	yes	Chest pain or discomfort.....no	yes
Leg cramps with walking...no	yes	Swelling of hands/feet/ankles...no	yes	Palpitations/fluttering of heart...no	yes
Leg cramps at night.....no	yes	Blood in sputum.....no	yes	Purple fingers/lips.....no	yes

**Gastrointestinal:**

Difficulty swallowing.....no	yes	Nausea.....no	yes	Chronic constipation.....no	yes
Heartburn.....no	yes	Vomiting.....no	yes	Rectal bleeding.....no	yes
Abdominal pain/cramps.....no	yes	Frequent diarrhea.....no	yes	Black tarry stools.....no	yes

**Genitourinary:**

Frequent urination (day).....no	yes	Leakage of urine.....no	yes	Lack of sex drive.....no	yes
Frequent urination (night).....no	yes	Difficulty in starting urine.....no	yes	Kidney stones.....no	yes
Painful or burning urination...no	yes	Blood in urine.....no	yes	Frequent bladder infections...no	yes

**Musculoskeletal:**

Low back pain.....no	yes	Joint pain or stiffness.....no	yes	Swollen joints.....no	yes
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**Neuropsychiatric:**

Trouble sleeping.....no	yes	Seizures.....no	yes	Memory loss.....no	yes
Dizziness/fainting spells.....no	yes	Numbness or tingling.....no	yes	Depression.....no	yes
Severe headaches.....no	yes	Anxiety or panic attacks.....no	yes	Thoughts of suicide.....no	yes

**Men only:**

Discharge from penis.....no	yes	Pain or lump in testicles.....no	yes	Impotence.....no	yes
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**Women only:**

Age period began _____	Painful periods?.....no	yes	Any itching in vaginal area?.....no	yes
How many days do periods last? _____	Do you have PMS symptoms?.....no	yes	Pain with intercourse?.....no	yes
How many days between periods? _____	Date of last period _____	Type of birth control used _____	Number of pregnancies _____	
Is the flow heavy?.....no	yes	Date of last pelvic exam _____	Number of full term births _____	
Spotting between periods?.....no	yes	Date of last mammogram _____	Number of preterm births _____	

SIGNATURE OF PATIENT OR PARENT OF MINOR CHILD

DATE