

Patient History Form - Page 1 of 3
(All Information Confidential)

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Name _____ Date _____

Parent/Guardian name (if child) _____ Your Birthdate _____

CURRENT MEDICAL HISTORY

Please describe briefly the health problem(s) you want to resolve. Describe symptoms that are bothering you now (headaches, indigestion, cramping, etc.)

What other forms of therapy have you used for your health concern(s) (medical doctors, chiropractors, acupuncturists, etc.)?

PAST MEDICAL HISTORY

Put an X next to the number for any of these conditions that you *now* have.

- | | |
|----------------------------------|--------------------------------------|
| 1. Anemia or blood disease | 21. Arthritis or joint pain or gout |
| 2. Neck/back injury or pain | 22. Broken bones or bone injury |
| 3. Orthotic appliances in shoe | 23. Scoliosis (curved spine) |
| 4. Operations (list below*) | 24. Eye problems |
| 5. Injuries needing medical help | 25. Ear trouble (deafness) |
| 6. Ringing ear, popping jaw | 26. Sinus problems |
| 7. Persistent cough | 27. Recent weight gain or loss |
| 8. Shortness of breath, asthma | 28. Pneumonia, bronchitis |
| 9. Racing heart | 29. Heart disease, hypertension |
| 10. Chest pain – angina | 30. Rheumatic fever - heart murmur |
| 11. Varicose veins or phlebitis | 31. Poor circulation/swelling ankles |
| 12. Allergy – hay fever | 32. Skin disease – rash, moles |
| 13. Cancer or tumor | 33. Stomach/gallbladder trouble |
| 14. Hemorrhoids/rectal bleeding | 34. Kidney or bladder trouble |
| 15. Painful, frequent urination | 35. Hepatitis, liver trouble |
| 16. Sugar or albumin in urine | 36. Diabetes mellitus |
| 17. Thyroid disease | 37. migraine headache |
| 18. Dizziness or fainting spells | 38. Epilepsy/ convulsions |
| 19. Fatigue Weakness | |
| 20. Other illnesses | |

Please list major Hospitalizations/Surgeries and approximate dates

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FAMILY HISTORY

For your blood relatives list any of these conditions. If deceased, the cause of death (if known) and age at death. (Examples: Alcoholism, allergies, autism, bleeding, cancer, Crohn's disease, diabetes, heart disease, high blood pressure, mental disorders, osteoarthritis, rheumatoid arthritis, stroke, thyroid disease, tuberculosis)

Father _____
Mother _____
Brothers/sisters _____

MEDICATION & VITAMINS or SUPPLEMENTS

List any prescription (or over-the-counter) medication you are now using (or are supposed to be using)

List vitamins and supplements you take regularly

List any known drug allergies and your reaction to the drug

How often do you drink the following (never, occasionally, daily, weekly etc.)

Regular soft drinks _____ Diet soft drinks _____
Cups or glasses regular/black tea _____
Cups of regular coffee _____
Other beverages (list) _____

HABITS and EXPOSURES

Have you ever smoked cigarettes/used tobacco? _____
If yes, are you smoking now? _____ How many? _____
Alcohol (indicate daily or monthly) _____
Exercise (Daily Weekly Occasionally Never)? _____ What type exercise? _____
Do you have constipation or diarrhea or abdominal bloating? (Which?) _____
How often are your bowel movements? _____

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SYMPTOMS

Do you have any problems with fatigue or low energy? _____
Is there a particular time that seems worse? _____
What is your usual temperature (unknown, low, normal, high)? _____
Describe sleep (OK, waking often etc.) _____

Which of these are *currently* concerns or problems?(Circle)

Nervousness – Depression – Fears - Shyness
Sexual problems - Suicidal thoughts – Finances - Anger
Stress/Anxiety - Tiredness/fatigue - PMS
Career choices - Pain - Regrets - Drug use
Self control - Work - Inferiority - Legal matters
Enemies - Grieving - Making decisions - Separation
Alcohol use - Unhappiness - Unpleasant memories
Relaxation - Memory - Loneliness - Temper
Marriage - Thoughts (repeated) - Social Skills – Dizziness
Divorce – Friends – Headaches – Ambition
Children – Parenting – Motivation - Concentration/focus

Additional comments or concerns not addressed above

FEMALES ONLY

Menstrual cycle: regular irregular painful heavy
First day of last menstrual period _____

Menopausal (no longer cycling) (for how long?) _____

Hysterectomy (total or partial and year) _____

Last Pap _____ Results _____
Number of Pregnancies _____ Children (ages) _____

Are you now taking birth control pills? _____