Northern California Center
for Lifestyle Medicine
P: 916-351-8100
www.ncclm.com

PATIENT MEDICAL PROFILE

Last Name: ___________________________________ First Name: __________________________________

Nickname: ____________________ Birthdate: ______________ Age: _________ Gender: _______________

A note to our patients: Please complete this two-paged questionnaire as thoroughly as possible in order to best aid in your diagnosis and treatment. This is a confidential record of your medical treatment and will not be released, except when you have provided us with written authorization to do so. Thank you.

PRESENT HEALTH CONCERNS

Please list most important health concerns in their order of significance.	Is there a prior diagnosis of this problem? If so, what was diagnosis, when was it made and by whom?
1.	
2.	
3.	
4.	
5.	

What goals do you have for your visit to our clinic today? ____

____

List prescription medications that you are currently taking, with dosages:

1. ____________________________ 2. ___________________________ 3. ___________________________
4. ____________________________ 5. ___________________________ 6. ___________________________

List vitamins, minerals, herbs, homeopathic remedies that you are currently taking, with dosages:

1. ____________________________ 2. ___________________________ 3. ___________________________
4. ____________________________ 5. ___________________________ 6. ___________________________

List any severe or life-threatening allergies and reactions: ____

____

Name ____ DOB: ______________________________

Current Symptoms (please check with pen)

General
- o Chills
- o Fatigue
- o Fever
- o Night Sweats
- o Weight Change

Eyes
- o Blurred Vision
- o Eye Drainage
- o Eye Pain
- o Glasses/contacts
- o Light Sensitivity

Ears/Nose/Throat
- o Ear pain
- o Hearing problems
- o Ringing in ears
- o Nose bleeds
- o Nasal congestion
- o Nasal ulcers
- o Runny nose
- o Bleeding gums
- o Gum disease
- o Dentures present
- o Hoarseness
- o Oral ulcers
- o Sore throat
- o Sore tongue
- o Thrush
- o Tooth pain

Cardiovascular
- o Chest pain
- o Leg pain w/ walking
- o Dizziness
- o Shortness of breath
- o Palpitations
- o Swollen feet/ankles
- o Rapid heart rate
- o Varicose veins

Respiratory
- o Cough
- o Difficulty breathing
- o Coughing up blood
- o Chest wall pain
- o Wheezing

Gastrointestinal
- o Abdominal pain
- o Indigestion
- o Sour taste in mouth
- o Poor appetite
- o Bloating
- o Difficulty swallowing
- o Clay-colored stools
- o Constipation
- o Diarrhea
- o Heartburn
- o Vomiting blood
- o Bloody stools
- o Hemorrhoids
- o Dark/tarry stools
- o Nausea
- o Vomiting
- o Painful chewing
- o Stool caliber change

Genitourinary
- o Bleeding after intercourse
- o Blood in urine
- o Change in urine stream
- o Frequent bacterial vaginosis
- o Frequent Bladder infections
- o Frequent urination
- o Genital lesions
- o Heavy periods
- o Impotence
- o Irregular periods
- o Menopausal bleeding
- o Menopausal symptoms

Genitourinary (con't.)
- o Nighttime urination
- o Painful intercourse
- o Painful menstruation
- o Painful urination
- o Sexual abuse
- o Unprotected sex
- o Urinary incontinence
- o Vaginal discharge
- o Vaginal itching

Musculoskeletal
- o Arm or leg pain
- o Back pain
- o Joint pain
- o Joint stiffness
- o Muscle aches

Skin
- o Acne
- o Concerning moles
- o Dry skin
- o Fingernail problems
- o Jaundice (Yellow skin)
- o Itching
- o Rashes
- o Warts

Breast
- o Lump
- o Skin changes
- o Breast tenderness
- o Nipple discharge
- o Regular self-breast exams

Neurological
- o Difficulty walking
- o Dizziness (fainting)
- o Fainting
- o Headaches
- o Memory loss
- o Numbness

Neurological (con't.)
- o Seizures
- o Tremor
- o Vertigo (Dizziness)
- o Weakness

Hematologic
- o Easy bruising
- o Excessive bleeding
- o Blood transfusions
- o Enlarging lymph nodes

Endocrine
- o Enlarging hands/feet
- o Hair loss
- o Heat intolerance
- o Cold intolerance
- o New hair growth
- o Hot flashes
- o Darkening skin
- o Infertility
- o Increased thirst
- o Increased hunger
- o Stretch marks
- o Sweating excessive

Allergies/Immunologic
- o Allergies
- o Hay fever
- o Frequent colds
- o HIV exposure
- o Urticaria (Hives)

Psychiatric
- o Anxiety
- o Depression
- o Stress
- o Mood Disorders
- o PMS
- o Poor concentration
- o Trouble sleeping
- o Suicidal thoughts

Name ____ **DOB:** _______________________________

Other Healthcare Providers you are currently seeing. (List all – conventional, holistic, integrative…etc.)

Dr. _________________________for ______________________ Dr. _________________________for ______________________

Dr. _________________________for ______________________ Dr. _________________________for ______________________

Date of last physical/annual exam ______________________ Date of last blood tests: ________________________________

Surgical History (please list surgeries, dates and outcomes)

Family History

Relation	**Medical Condition**	**Age at Death**	**Cause of Death**
Father			
Mother			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			
Paternal GF			
Paternal GM			
Maternal GF			
Maternal GM			

Name ____ DOB: _______________________________

Pregnancy/Gynecological History

Pregnancies # _____

Children # _____

Miscarriages # _____

Terminations # _____

Problems during pregnancy?
______

- o Menstrual problems
- o Hysterectomy
- o Total
- o Partial (ovaries retained)

Current Birth Control Method
____

Are you happy with current birth control method?

Age periods started _____

Age at menopause _____

Last Pap Smear (date)
____

Last Mammogram (date)
______

Social History

Occupation _______________
Marital Status ____________
Hobbies _________________
____

Exercise (type and frequency)
____
____

Children? Names and ages
____
____

Caffeine
Type and number of drinks per day ______________________
____

Smoking
Current? In the past? Never?
How long? ______________
Type? Cigarettes? Cigar? Smokeless?

How often do you use Alcohol?

- o None
- o Rare
- o Social
- o Regular
- o Occasional Binge
- o Current Alcoholic
- o Past Alcoholic
- o Used alcohol in past

Recreational Drugs

- o Frequency __________
- o Types_______________
- o How long? _________

Do you Restrict any Foods?
Which? __________________
____