DOW EXECUTIVE CHECKUP

PATIENT HISTORY FORM

Date -_____

Personal History

Name: _____ Date of Birth____/____/_____(mm/dd/yyyy) Age_____

Occupation _____ Birthplace_____(City & Country)

Height_____inches Weight_____(lbs or Kg)

Preferred Language for consultation –1st_____2nd_____(English, Hindi, Urdu, Punjabi)

Patient Ph#_____ cell # _____

ALLERGIES: Like – Food, Pollens, Odors, Medicines, Pets etc…

_____

_____

_____

MAIN PROBLEMS FOR CONSULTATION: **(if possible, rank in terms of importance to you)**

1. _____
2. _____
3. _____
4. _____
5. _____

Additional problems or concerns you would like to be addressed:

_____

_____

_____

_____

_____

_____

_____*Note: we may not be able to address every problem during the course of one treatment.

Current Medications	**Dose**	**Times / Day**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Current Herbs / Vitamins/ Homeopathy/ Supplements	**Dose**	**Times / Day**
_____	_____	_____

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

PAST MEDICAL, SURGICAL & TRAUMA HISTORY **Patient Name:**

List prior illness, injury, hospitalization, surgery, and/or trauma:

Reason: **Date/Month and Year**

_____
_____
_____
_____
_____

PERSONAL AND FAMILY HISTORY

Check those that apply and tick your problem if any..

	Yourself	Mother	Father	Grandparents	Sister/ Brother	Spouse	Children
Allergies							
Alzheimer's							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Disorder							
Breast Cancer							
Cancer							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart Disease							
High Blood Pressure							
IBS							
Kidney Disease							
Liver Disease							
Mental Illness							
Migraine Headaches							
Pneumonia							
Stroke							
Tuberculosis							
Ulcers							
Other							

SOCIAL HISTORY (check those that apply): **Patient Name:**

Marital status:	**Education level completed:**	**Memories of your childhood**	**Do You Find Your Life**
☐ single	☐ high school	☐ Mostly happy	☐ Generally Unsatisfactory
☐ married	☐ college	☐ Mostly painful	☐ Too Demanding
☐ divorced	☐ professional school	☐ Normal	☐ Boring
☐ Widowed	☐ other:	☐ don't recall	☐ Satisfactory

Living arrangement:

☐ alone ☐ family ☐ roommate ☐ significant other

☐ children (list sex/ages):_____

☐ Major stresses in last 2 years ☐ Money ☐ Job ☐ Marriage ☐ Home Life ☐ Children

☐ other stress_____

Pertinent travel history:(out of Country areas)

_____

_____

LIFESTYLE / SELF-CARE ISSUES

Do you smoke cigarettes?	☐ YES ☐ NO	If yes, how many? #_____yrs. _____ packs per day
Did you ever smoke?	☐ YES ☐ NO	If yes, when did you quit? _____
Do you drink caffeine beverages?	☐ YES ☐ NO	If yes, which? _____
Do you use recreational drugs?	☐ YES ☐ NO	If yes, which? _____
Do you manage stress well?	☐ YES ☐ NO	☐ NOT SURE ☐ NEED HELP
Do you exercise regularly?	☐ YES ☐ NO	If no, why? _____
Do you enjoy your job?	☐ YES ☐ NO	If no, why? _____
Do you sleep soundly?	☐ YES ☐ NO	If no, why? _____
Are you satisfied with your social life?	☐ YES ☐ NO	If no, why? _____
Are you satisfied with your spiritual life?	☐ YES ☐ NO	If no, why? _____
Is your diet healthy enough?	☐ YES ☐ NO	☐ NOT SURE ☐ NEED HELP

Typical breakfast_____

_

Typical lunch

_____

Typical dinner_____

Typical snacks_____

Devices

Do You Use:

___Eyeglasses _____Contact Lens _____Hearing Aid _____Dentures

___Brace (Neck, Back) _____ Pacemaker _____ IUD, Diaphragm _____Artificial Limbs

REVIEW OF SYSTEMS **Patient Name:**

Check any symptoms that currently apply to you:

Constitutional
___ poor appetite
___ fevers
___ chills
___ food craving
___ weight loss
___ weight gain
___ fatigue

Eyes
___ eye pain
___ blurred vision
___ poor vision___day
___ poor vision___night
___ wear corrective lenses
___ near____far sighted
___ other

Ears, Nose
___ ringing ears
___ nosebleed/polyp
___postnasal drip
___sinus problems
___trouble with taste/smell
___poor hearing
___earaches/ infections
___sneezing/ discharges

Mouth, Throat
___ tongue discoloration
___ bad breath
___ teeth problems
___ grinding teeth
___ tonsillitis/ adenoids
___ facial pain
___ sore throat
___ ulceration tongue
___ gum bleeding

Heart & Circulation
____chest pain
____ lightheadedness
___ palpitations
____ cold hands/feet
____ fainting
____ swelling feet
____ blood clots
____ varicose veins

Breathing & Lungs
_____shortness of breath
_____wheezing or asthma
_____repeated colds/ flu
_____ cough dry/ irritating

Muscles, Bones & Joints
____neck pain
____back pain
____muscle pain
____ painful joints: R__L__
____shoulder ____elbow
____hip____ knee ___ankle
____wrist _____fingers
____joint swelling
____muscle weakness
____muscle cramps

Skin, Hair
____ psoriasis
____ warts
____ freckles
____ itching, hives
____ hair loss
____ dry skin, eczema

Nerves, Movement, Brain
_____ seizures
_____nerve pain
_____poor balance
_____poor coordination
_____tremors or shaking
_____headaches

Digestion & Intestines
____indigestion
____belching/ flatulence
____difficulty swallowing
____heartburn/ ulcer
____nausea
____ liver trouble
____ vomiting
____ diarrhea
____ cramping bowels
____ food allergies
____constipation
____ abdominal pain
____rectal pain/ itching
____ hemorrhoids/ piles
____ blood in stool

Urine, Kidney, Bladder
____painful urination
____wake up to urinate
_____kidney stones
____ loss of control
____ frequent urination
____ sudden urging
____ blood/pus urine
____urine infection UTI

Immune System
_____too many infections
____allergies to food
____allergies to environment
___ other concerns

Blood System
____lymph gland swelling
____anemia
____easy bruising

Mind Symptoms
____memory
____temper/anger

Sexual Organs
____ sores on genitals
____ lumps or swelling
____ erection problems
____ premature ejaculation
____pain with sex
____infertility
____repeated infections
____aversion to sex

Thermal State
___hot
___chilly

Women
_____ pelvic pain
_____ vaginal discharge
_____ painful periods
_____premenstrual syndrome
_____ hot flashes
_____ itching or soreness
_____irregular menses
_____leucorrhoea

Reproductive
____age period started
____ # of pregnancies
____# abortions
____# miscarriages
____# live births
___children currently living
___age menopause ___
___past infertility

____emotional
____sleep

Additional Symptoms --

_____
_____
_____
_____

IF NOT NOTED IT IS EITHER NEGATIVE, NON-CONTRIBUTORY, AND/ OR NON-PERTINENT.

HEALTH SCREENING HISTORY **Patient Name:**

List the date of your most recent test or exam.

Mammogram _____ Pap Smear_____ Self Breast Exam _____Breast Exam by Doctor_____
Blood test for Cholesterol _____ Blood Sugar _____Other Blood tests_____
Immunizations: Tetanus_____Hepatitis_____MMR_____Flu Shot_____
Test for Blood in stool_____ Rectal Exam _____Feeling the Prostate_____ Scope Lower Bowel_____
Self Exam Testicle _____Testicle Exam by Professional_____

Anatomy\Procedure	X-ray	MRI	CT Scan	Ultrasound	Bone Scan	EKG	EEG
Back							
Brain							
Chest							
Colon							
Extremities (Arm/ Leg)							
Gallbladder							
Kidney							
Neck							
Pelvis							
Stomach							
Other							

>>Copies of reports should be sent with the patient form

_____
Date Patient/ Guardian signature that filled out the history

Address;_____ **Phone – Home --** _____

Cell -- ______________________________

Email -- ______________________________