KATHLEEN M. THOMSEN MD, MPH, ABIHM
Holistic Health and Wellness
252 West Delaware Avenue
Pennington, NJ 08534
609-818-9700

MEDICAL HISTORY FORM

Today's Date_____

Name_____Age_____Birth Date_____
Street Address_____
City_____State_____Zip Code_____
Home Phone_____Fax_____
Cell Phone_____E-mail_____
Birthplace_____# of Years of Education_____
Race_____ Social Security #_____
Religion_____Marital Status_____ # of Children_____
Children's Names/Ages *(include last name if different from yours)*_____
_____
_____

Occupation_____ Work Phone_____
Employer's Name_____
Employer's Address_____
City_____State_____Zip Code_____
Primary Medical Insurance _____
Insurance Group #_____ ID #_____
Spouse's Name *(if applicable)*_____ Occupation_____
Person to Contact for Emergency_____ Relation to You_____
His/Her Phone_____ His/Her Address_____
City_____State_____Zip Code_____

How Did You Find Out About Our Practice?_____

Reason For Initial Visit:
Reason for my initial visit:_____
_____
_____

I would like to have my annual PAP, breast and pelvic exam at this initial visit: ☐ Yes ☐ No

Other things I would like to discuss on this visit or future visits:_____
_____
_____

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

Past Medical / Surgical History:

Current Health Issues	Name of Provider Treating You
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Health Issues	Name of Provider Who Treated You
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Surgeries	Approx. Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Reason for Other Hospitalizations	Approx. Date	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Accidents	Dates	Consequences
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any illnesses, pregnancies, or surgeries interfered with your being a wife/mother/partner or changed the way you feel about yourself as a woman? If yes, please explain

_____
_____
_____

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

Medications / Supplements:

Medication	Dose	Frequency

Vitamins/Nutritional Supplements	Dose	Frequency

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

Allergies / Reactions:

Allergies to Medications	Reactions

Allergies to Foods	Reactions

Environmental Allergies *(contact e.g. pets, airborne e.g. pollen)*	Reactions

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

Exposure History:
PETS currently/recently exposed to:

_____ _____ _____
_____ _____ _____

TRAVEL Outside US within the last year:

Date	Place	Date	Place
_____	_____	_____	_____
_____	_____	_____	_____

BLOOD TRANSFUSIONS done in the past:

Date	Hospital	Reason for Blood Loss
_____	_____	_____
_____	_____	_____

PROSTHESES currently in use: (eg. False teeth, contact lenses/glasses, artificial hip/heart valve, etc.)

_____ _____
_____ _____

Did your mother take DES (A drug given from the late 1940's – 1971 to prevent miscarriage and premature births) when she was pregnant with you? ☐ Yes ☐ No ☐ Don't Know

Are you concerned about any workplace exposures (chemicals, physical stresses, etc.)?_____
If so, please explain:_____
_____

Do you maintain any cultural practices which you believe affect your health (eg. special diets, stressors, supports, folk healing methods)? ☐ Yes ☐ No
If so, please describe:_____
_____

Do you use any complementary/alternative healing methods (eg. acupuncture, herbs, homeopathy, therapeutic touch, massage, chiropractic, etc.)? ☐ Yes ☐ No
If yes, please describe:_____
_____
_____

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

Sexual / Reproductive History:
Circle, check, or fill in the blank

Are you in a relationship that includes sexual intercourse?

- ☐ Yes, Currently
- ☐ Not currently (estimated last time you had intercourse _____)
- ☐ Have never been

Current sexual partner(s) is/are: ☐ Male ☐ Female ☐ Both

Previous sexual partners were: ☐ Men ☐ Women ☐ Both

Number of sexual partners in past year_____ Number in lifetime_____

Number of sexual partners your partner has had in last year_____

(Circle) Do you (always / most always / sometimes / never) practice "safe sex"?

Date of most recent test for HIV_____ Result_____

Have you ever had: *(if yes, please explain what and when)*

A sexually transmitted disease?_____

A partner who had a sexually transmitted disease?_____

A prior partner who had a sexually transmitted disease?_____

An abnormal PAP smear?_____

Vaginitis *(yeast, bacterial vaginosis, trichomonas)*_____

Any surgeries, diseases or medications that altered your ability to function sexually?

_____

Other information about your sexual history you would like us to know:_____

_____

_____

Date of last menstrual period_____ Duration *(number of days)*_____

Timing of last period: ☐ On Time ☐ Late ☐ Early

Flow of last period: ☐ Normal ☐ Heavier ☐ Lighter

If on birth control pills or hormone replacement therapy, were any pills missed?_____

Age first period began_____ Length of flow for your typical period *(days)*_____

Cycle length (*days from start of one period to start of next)*_____

Menstrual blood flow is usually: ☐ Light ☐ Moderate ☐ Heavy

Menstrual discomfort is usually: ☐ Slight ☐ Moderate ☐ Severe

Premenstrual problems are usually: ☐ Slight ☐ Moderate ☐ Severe

I usually use: ☐ Sanitary Napkins ☐ Tampons ☐ Both

Problems or pain with pelvic examination_____

Other information about your menstruation you would like us to know:_____

_____

Outcome of any Pregnancies *(live birth, stillbirth, premature, miscarriage, abortion)*	Problems	Month/Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever breast fed? ☐ No ☐ Yes (length of time _____)

Are you currently breast feeding? ☐ No ☐ Yes

Are you currently trying to become pregnant? ☐ No ☐ Yes

If yes, how long have you been trying?_____

Contraceptive History: if heterosexual

Current method of birth control_____

Are you satisfied with this method? ☐ No ☐ Yes

Have you had sex without birth control since your last period? ☐ No ☐ Yes

Have you had a tubal ligation? ☐ No ☐ Yes (When/Where_____)

Has your partner had a vasectomy? ☐ No ☐ Yes (When/Where_____)

Method of past contraception	Problems/Reasons for discontinued use
Birth control Pills_____	_____
IUD_____	_____
Diaphragm_____	_____
DepoProvera *(the shot)*_____	_____
Norplant_____	_____
Condoms_____	_____
Foam, Sponge, Film_____	_____
Other_____	_____

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

Social History:

Circle, check, or fill in the blank

Do You currently smoke cigarettes? ☐ No ☐ Yes (#/day_____ # of years_____)

(If you have quit smoking, Congratulations! Please answer the following:

Number of cigarettes/day you used to smoke_____

Number of years you used to smoke_____

How long ago did you quit?_____)

If you currently smoke, what brand of cigarette do you smoke?

☐ filtered ☐ non-filtered ☐ light ☐ a variety of brands

If you currently smoke, are you interested in quitting? ☐ Yes ☐ No

If yes, are you interested in quitting in the next (circle): 6 months / 1 month

I am exposed to passive smoke from someone in my (circle): household / workplace / other

I drink _____ alcoholic beverages per week in the form of (circle): beer / wine / liquor

How many drinks does it take before you feel an alcoholic effect? _____

Do people in your household drink frequently? ☐ Yes ☐ No

Are you interested in quitting drinking? ☐ Yes ☐ No

If yes, are you interested in quitting in the next (circle): 6 months / 1 month

Have you used any recreational drugs in the past? ☐ Yes ☐ No

If yes, please list: _____

_____

Do you currently use recreational drugs? ☐ Yes ☐ No

If yes, please list: _____

_____

Have you used needles to inject yourself with drugs? ☐ Yes (currently / in the past) ☐ No

If yes, have you shared needles with others? ☐ Yes (currently / in the past) ☐ No

Have you had sexual relations with a partner that has used needles to inject drugs?

☐ Yes (currently / in the past) ☐ No

Do you worry about the possibility of becoming HIV positive or getting AIDS? ☐ Yes ☐ No

Have you ever used diet pills? ☐ Yes (currently / in the past) ☐ No

Have you ever used laxitives? ☐ Yes (currently / in the past) ☐ No

Have you ever used sleeping aides? ☐ Yes (currently / in the past) ☐ No

Have you ever used sedatives? ☐ Yes (currently / in the past) ☐ No

I drink _____ cups of coffee per day. I drink (circle): Caffeinated / Decaffeinated

I drink _____ cups of iced/hot tea per day. I drink (circle): Caffeinated/Decaffeinated

I drink _____ glasses of soda per day. I drink (circle): Caffeinated / Decaffeinated

Are you exercising regularly? ☐ Yes ☐ No

Type of exercise	Duration	Frequency
_____	_____	_____
_____	_____	_____

Foods You ate Yesterday:

Breakfast	Lunch	Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Stress can cause a lot of physical problems. Have you been under stress lately? Yes / No

If Yes, to what do you attribute your current stress (eg. job, partner, family, illness, etc.)

_____

_____

How do you and your partner handle conflicts *(If applicable)*?_____
_____
_____

In handling conflict, does anyone ever get hurt? ☐ Yes ☐ No
If so, who? _____

Physical fighting is a problem in some relationships. Have you ever been hit, kicked or bitten by your partner *(If applicable)*?_____

Have you been verbally abused by your partner (eg. intimidated/humiliated, put down, treated with disrespect, etc.)? _____

Have you ever been forced to perform sexual acts that were uncomfortable for you?_____

Does your partner try to control you by controlling money or check up on where you have been?_____

Have you ever been sexually abused or raped? ☐ Yes ☐ No

If so, did you receive counseling? ☐ Yes ☐ No

Are you or have you ever been the victim of sexual harassment? ☐ Yes ☐ No

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

Family History:
(Fill in with any significant health problems for each family member deceased or alive)

Family Member	Medical Problem(s)	Age **or**	Age at Death
Mother	_____	_____	_____
Father	_____	_____	_____
Mother's Mother	_____	_____	_____
Mother's Father	_____	_____	_____
Father's Mother	_____	_____	_____
Father's Father	_____	_____	_____
Brothers/Sisters	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Partner *(if applicable)*	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

MEDICAL HISTORY FORM

Have any of these problems occurred in you or your family *(check where appropriate)*?

	You	Your Family		You	Your Family
Breast cancer	☐	☐	Epilepsy	☐	☐
Ovarian cancer	☐	☐	Sickle cell anemia	☐	☐
Cervical cancer	☐	☐	Tuberculosis	☐	☐
Uterine cancer	☐	☐	Diabetes	☐	☐
Colon cancer	☐	☐	Mental retardation	☐	☐
Lung cancer	☐	☐	Birth defects	☐	☐
Skin cancer	☐	☐	Tay Sachs disease	☐	☐
Other cancers	☐	☐	Anemia	☐	☐
Heart disease	☐	☐	Bleeding problems	☐	☐
Heart attack	☐	☐	Obesity	☐	☐
High blood pressure	☐	☐	Eating disorders	☐	☐
Stroke	☐	☐	Suicide	☐	☐
Osteoporosis	☐	☐	Alcoholism	☐	☐
Depression	☐	☐	Drug abuse	☐	☐
Physical abuse as child	☐	☐	Mental illness	☐	☐
Sexual abuse as child	☐	☐	Ulcers	☐	☐
Abused as an adult	☐	☐	Violent outbursts	☐	☐
Asthma	☐	☐	Phlebitis, blood clots	☐	☐
Eczema, hives, rashes	☐	☐	Rheumatic fever	☐	☐
Eye problems	☐	☐	Heart murmurs	☐	☐
Glaucoma	☐	☐	Mitral valve prolapse	☐	☐
Kidney/bladder probs.	☐	☐	Thyroid disease	☐	☐
Kidney stones	☐	☐	Neuro probs. (eg. MS)	☐	☐
Gallstones	☐	☐	Alzheimer's disease	☐	☐
Lung disease	☐	☐	Other:_____	☐	☐
Liver disease, hepatitis, yellow jaundice	☐	☐	_____		

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

Prevention and Screening:
Approximate dates of immunizations:

	Date		Date
Diptheria	_____	Tetanus	_____
Polio	_____	Hepatitis B	_____
Measles	_____	Influenza	_____
Mumps	_____	Pneumococcus	_____
Rubella	_____		

Most current dates of following tests with outcome (N=Normal; A=Abnormal):

	Date	N or A		Date	N or A
Cholesterol	_____	_____	Breast exam by doctor	_____	_____
Hearing exam	_____	_____	Mammography	_____	_____
Eye exam	_____	_____	Test for blood in stool	_____	_____
Dental exam	_____	_____	Sigmoidoscopy/Colonoscopy	_____	_____
Pap & Pelvic	_____	_____	Complete skin exam	_____	_____
DEXA (Bone Density)	_____	_____	PPD (test for tuberculosis)	_____	_____

♦ ♦ ♦ ♦ ♦ ♦ ♦ ♦

Review of Symptoms:
Please check if you currently have any of these symptoms or have had them in the past:

	Current	Past
Headaches	☐	☐
New weakness in one arm or leg	☐	☐
Numbness in one arm or leg	☐	☐
Momentary darkness in one eye	☐	☐
Momentary garbled speech or drooling	☐	☐
Changes in your vision	☐	☐
Changes in your hearing	☐	☐
Difficulty chewing food	☐	☐
Loose or missing teeth	☐	☐
Bleeding gums	☐	☐
Difficulty swallowing	☐	☐
Chest pain or pressure	☐	☐
Pain radiating from chest to arm or jaw	☐	☐
Shortness of breath with minimal exertion	☐	☐

Review of Symptoms (Cont'd.)

	Current	Past
Dizziness	☐	☐
Palpitations or racing heart	☐	☐
Swollen feet or ankles	☐	☐
Pain in back of legs after walking short distance	☐	☐
Dry cough	☐	☐
Cough that brings up phlegm or sputum	☐	☐
Coughing up blood	☐	☐
Persistent or bloody nipple discharge	☐	☐
Indigestion, burning or sour stomach	☐	☐
Nausea or vomiting	☐	☐
Frequent belching	☐	☐
Abdominal bloating or swelling	☐	☐
Abdominal pain	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Blood in stool or black tarry stool	☐	☐
Change in appearance of stools	☐	☐
Pelvic pain	☐	☐
Pain with intercourse	☐	☐
Vaginal bleeding other than periods	☐	☐
Vaginal itching, burning or unusual discharge	☐	☐
Vaginal dryness	☐	☐
Burning when urinating	☐	☐
Losing urine when coughing, sneezing or jumping	☐	☐
Very frequent urination	☐	☐
Sense of urgency to urinate; can't hold urine	☐	☐
New rashes or dark spots on skin	☐	☐
Frequent sunburns; tanning salon	☐	☐
Night sweats	☐	☐

MEDICAL HISTORY FORM

Review of Symptoms (Cont'd.)

	Current	Past
Hot flashes/flushes	☐	☐
Problems with memory	☐	☐
Changes in sleep habits	☐	☐
Disinterest in usual hobbies/interests	☐	☐
Feelings of guilt	☐	☐
Lack of energy	☐	☐
Inability to concentrate	☐	☐
Changes in appetite	☐	☐
Loss or gain of more than 10 pounds in 6 months	☐	☐
Thoughts of wanting to hurt yourself	☐	☐
Thoughts of wanting to hurt others	☐	☐
Frequent dieting	☐	☐
Lack of adequate nutrition	☐	☐
Lack of adequate exercise	☐	☐
Unable to take care of yourself (wash, dress, cook)	☐	☐
Unable to do things you used to do for yourself	☐	☐
Frequent falling	☐	☐
Getting up at night to urinate	☐	☐
Bingeing and purging food	☐	☐
Concern for your physical safety	☐	☐
Belief that someone is abusing you	☐	☐
Trouble at work or school	☐	☐
Concern with exposures/health safety at work	☐	☐
Family problems	☐	☐
Feeling overwhelmed; stressed out	☐	☐
Feelings of anxiety, nervousness	☐	☐