

Chaney Integrative Family Medicine

2000 West 47th Place

Westwood, KS 66205

Tel (816) 588-2220 Fax (816) 268-4599

PATIENT INFORMATION

NAME _____ BIRTH DATE _____ AGE ____ SEX M F MARITAL STATUS _____

ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ SS# _____

OCCUPATION _____ EMPLOYER _____

IF RETIRED, PREVIOUS OCCUPATION _____ CHILDREN _____ AGES _____ GENDER _____

EMERGENCY CONTACT _____

NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

HOW DID YOU HEAR ABOUT DR. CHANEY? _____ E-mail ADDRESS _____

PLEASE LIST YOUR HEALTH CONCERNS:

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

MEDICAL HISTORY

Please check any of the following that apply and note when they started

- | | | |
|--|--|---|
| <input type="checkbox"/> AIDS/HIV Infection | <input type="checkbox"/> Frequent Antibiotic Use | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Frequent Steroid Use | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> German measles | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Giardia/Parasites | <input type="checkbox"/> Neurological Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Occupational Exposure to Toxic Substances |
| <input type="checkbox"/> Attempted Suicide | <input type="checkbox"/> Gout | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever/Scarlatina |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Herpes | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sexually Transmitted Diseases (warts, herpes, gonorrhea, syphilis, etc.) |
| <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> Hives | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Colitis / Crohn's Disease | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Substance Abuse/Addiction |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Infections | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> TIA's (mini-strokes) |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Edema (Fluid Retention) | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Vaccine Reaction |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Measles | |

Other: _____

Review of Systems

Please indicate the following N= a condition you have NOW P= a condition you have had in the PAST

Skin Dry _____ Oily _____ Itching _____ Rashes _____ Hives _____ Fungal Infections _____ Bruise Easily _____ Slow Healing _____ Warts _____ Moles _____ Where? _____ How Many? _____ Nails Soft _____ Break _____	Mouth Dryness _____ Excessive Salivation _____ Tongue: Sore _____ Coated _____ Canker Sores _____	Urinary (cont.) Frequent Urination Day _____ Night _____ Frequent Bladder Infections _____
Head Migraines _____ Headaches _____ Location of pain _____ Worse: Light _____ Noise _____ Odors _____ Head Injury _____ Describe _____ TMJ _____ Dizziness _____ Fainting _____ Seizures _____	Respiratory Pneumonia _____ Bronchitis _____ Cough _____ Spit up Blood _____ Asthma _____ Wheezing _____ Shortness of Breath _____ Positive TB Test Ever _____	Muscular/Skeletal Back Pain _____ Pain in Muscles/Joints/Bones _____ Stiffness/Swelling _____ Muscle Weakness/Tremor _____ Numbness/Tingling _____ Shooting Pain _____ Paralysis _____ Any Side Worse? R _____ L _____ Ever Broke Bones? _____ Which _____ Ever Sprain Joints? _____ Which _____
Eyes Vision Disturbance _____ Dryness _____ Tearing _____ Pain _____ Styes _____ Infections _____ Sensitive to Light _____	Cardiovascular Chest Pain _____ Heart Palpitations/Racing _____ Heart Disease _____ Murmur _____ High _____ Low _____ Blood Pressure _____ Varicose Veins _____ Phlebitis _____ Leg Pains _____ Cramps _____ Ankle Swelling _____ Cold Hands _____ Feet _____	Energy (scale of 1-10) 1=worst 10=best _____ Best Time of day _____ Worst Time _____
Ears Discharge _____ Pain _____ Itch _____ Impaired Hearing _____ Ringing _____	Digestion Bowel Movement _____ X per day: 1-2 _____ 2-3 _____ 3-4 _____ or X per week: 1-2 _____ 2-3 _____ 3-4 _____ Size: Sm _____ Med _____ Lg _____ Color: Brown _____ Tan _____ Rust _____ Texture: Dry _____ Hard _____ Wet/Loose _____ Pellets _____ Stools with Mucous _____ Blood _____ Hemorrhoids _____ Bleeding _____ Painful _____ Itching _____ Fissures/Fistulas _____ Stool Incontinence _____ Bowel Disease _____ Liver/Gallbladder Disease _____ Ulcer _____ Heartburn _____ Bloating _____ Belching _____ Gas / Flatus _____ Nausea / Vomiting _____ Pains / Cramps _____	Sleep Good _____ Bad _____ How many hours? _____ Wake Easily? Y/N _____ Why? _____ When? _____ Difficulty Falling Asleep Y/N _____ Wake Refreshed? Y/N Grumpy? Y/N _____ Snore Y/N Talk Y/N _____ Grind Teeth Y/N Sleepwalk Y/N _____ Nightmares Y/N Dream a lot Y/N _____ Preferred Sleeping Position _____
Nose Seasonal Allergies _____ Drainage _____ Color: Clear _____ Yellow _____ Green _____ Texture: Runny _____ Thick _____ Post Nasal Drip _____ Stuffiness _____ Sneezing _____ Sinus Infections _____ Nosebleeds _____	Urinary Difficult Urination _____ Painful Urination _____ Incontinence/Dribbling _____ Blood in Urine _____ Bedwetting _____	Temperature Sensitive to: Hot _____ Cold _____ Both _____ Prefer: Inside _____ Outside _____ Warm blooded _____ Cold blooded _____ Best Season _____ Worst Season _____ Perspiration Sweat Easily Y/N _____ Sweat Excessively Y/N _____ Sweat Very Little Y/N _____
Throat/Neck Pain in Throat _____ Glands Enlarged _____ Difficult Swallowing _____ Change in Voice _____ Clears Throat Often _____		Appetite Excessive _____ Good _____ Poor _____ Foods you crave strongly _____ Foods you dislike strongly _____ Prefer foods Hot _____ Warm _____ Cold _____ Thirst: Excessive _____ Good _____ Poor _____ Prefer drinks: Very Hot _____ Hot _____ Warm _____ Cold _____ Ice cold _____ Recent Weight Change Y/N _____

Women Only

Date of Last Pelvic Exam _____
 Date/Results of Last Pap Smear _____
 Ever Have an Abnormal Pap Smear? _____
 DES Exposure _____
 Sexually Transmitted Disease _____
 History of Sexual Abuse _____
 Frequent Yeast Infections _____
 Vaginal Discharge _____
 Age Period Began _____
 Regular Periods Yes _____ No _____
 Flow: Heavy _____ Medium _____ Light _____
 Length of Cycle _____ Days of Flow _____
 Spotting _____
 Cramps _____
 PMS _____ Endometriosis _____ PID _____
 Fibroids _____ Ovarian Cysts _____
 Ever Used Birth Control Pills? _____
 How Long For? _____ How Long Ago? _____
 Present Birth Control _____
 Change in Sex Drive _____
 Painful Intercourse _____
 Pregnancies (number) _____
 Childbirth (number) _____
 Complications _____
 Miscarriages (number) _____
 Abortions (number) _____
 Impaired Fertility _____
 Have You Had A Hysterectomy? _____
 Age at Menopause _____
 Vaginal Dryness _____
 Hot Flashes _____
 Do You Do Self Breast Exams? _____
 Mammograms (number) _____
 Date of Last Mammogram _____

Past History

Hospitalization(s): _____

Serious Illnesses and Injuries: _____

Date of Last Physical _____
 Date of Last Blood Tests _____
 Date of Last Colonoscopy _____
 Date of Last DEXA (bone density test) _____

Personal Family History:

Please check the “yes” box next to each condition that applies to you or one of your family members. Please note whether the condition applies to you by writing the word “self” in the relation column. If the condition applies to a family member, please write the relationship to you in the relation column (e.g. mother, aunt, sister, father)

CONDITION	YES	RELATION	PAST (P) / NOW (N)
Alcoholism/Drug Addiction			
Allergies			
Alzheimer’s			
Anemia			
Arthritis			
Asthma			
Birth Defects			
Cancer			
Type?			
Depression			
Diabetes			
Eczema			
Epilepsy			
Headaches			
Heart Attack			
Heart Disease			
Hepatitis			
High Blood Pressure			
High Cholesterol			
Kidney Disease			
Learning Disability			
Mental Illness			
Mental Retardation			
Osteoporosis			
Stroke			
Suicide			
Thyroid Disease			
Tuberculosis			
Other			

Please list the names of your health care providers: _____

Do you have a specific spiritual practice? Y N If so, please describe it _____
 Is there anything the doctor should know in relation to this? _____

Please list all prescription and over the counter medications that you are currently taking:

Medication	Dose	Date Started	Prescribed By

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

Supplement	Dose	Date Started

Please list any severe or life-threatening allergies: _____

Please Explain _____

Personal Habits

Please indicate which substances, if any, pertain to you N= use NOW P= used in the PAST

Substance	N / P	How Much?	How Long?	Substance	N / P	How Much?	How Long?
Tobacco				Soda			
Coffee				Alcohol			
Black Tea				Recreational Drugs			

Do you have any dietary restrictions or follow a particular dietary regimen? If yes, please describe:

Do you exercise regularly? Yes No

What type? _____