PHYSICIANS EAST, P.A.
Providing Comprehensive Health Care To Eastern North Carolina

Personal Health History and Self Reflection Inventory

Name: _____ Date: _____
Age: _____ Date of birth: _____

What is the best contact phone #? _____
May we leave a message at this number? YES ___ NO ___
Preferred Pharmacy:
_____

Primary Care Provider (if not joining our Primary Care practice):
_____

Please list all physicians that you see. (Please include Mental Health Professionals)

Name	Address	Specialty, condition being treated

Please list any complementary and slash or alternative practitioners you see or have seen in the past (i.e. chiropractor, naturopath, acupuncture, massage therapist, spiritual healer, etc.)

Approximate Date (s) of Treatment	Name of Therapists or Treatment Facility	Type of Treatment (e.g. Reiki, Qi Gong, Sand Tray)	Reason for treatment	Beneficial experience?

What health issues do you want to focus on during this visit?

Is your primary care physician in the Physicians East system? YES ___ NO___
If yes, skip to Page 4

Current medical problems (e.g. diabetes, heart disease, hypertension, etc.):

1.	2.	3.
4.	5.	6.
7.	8.	9.

Past Medical History: Listening major past illnesses, hospitalizations (include year or date if known)

	Date:		Date:

Past Surgical History: List any past surgeries (and what year/date)

	Date:		Date:

If female-

GYN /OBGYN History: List past pregnancies.

Vaginal births		Miscarriage/Stillbirth	
C-sections		Pregnancy Termination	
Abnormal Pap tests		Other GYN Procedure	

Family History: have your close relatives (parent, brother or sister, child, grandparent) had the following?

Medical Condition	Yes	No	If yes, which relative	Age at Diagnosis
Heart attack, Angina				
Stroke				
High Blood Pressure				
High Cholesterol				
Diabetes				
Thyroid Disease				
Breast Cancer				
Other cancer – what type				
Kidney Disease				
Osteoporosis				
Rheumatoid Arthritis				
Asthma				
Mental Health Disorder				
Substance Abuse				

Pharmaceuticals and Supplements:

Do you have any medication allergies? Yes ___ No ___ if yes, please list:

Medication	Reaction	Medication	Reaction

Please list all medication and over-the-counter medications you take regularly.
Please include all supplements, vitamins or herbal products.

Medication/Supplement including dose	Frequency	Dose	Frequency
1.		8.	
2.		9.	
3.		10.	
4.		11.	
5.		12.	
6.		13.	
7.		14.	

Please outline your use of the following, past or present:

Product:	Current use? Yes /No	Quantity Per Day	Quantity Per Week	Past use? Yes/ No	Do others have concern about your usage?
Tobacco:					
Alcohol:					
Recreation Drugs:					
Caffeine:					

Preventive Health: Please provide the dates and documentation when possible

Do you routinely wear a seat belt? Yes ___ No ___

	Date		Date
Pap / pelvic exam (females)		Tetanus vaccine (Td or Tdap)	
Mammogram (females)		Flu vaccine	
Colonoscopy		Pneumonia vaccine	
Test of stool for blood (Stool Guaiac)		Zoster (Shingles) vaccine	
Rectal prostate exam (male)		Hepatitis A	
Prostate Specific Antigen (male)		Hepatitis B	
Bone density		MMR	
Eye exam		Gardasil HPB vaccine	
Cardiovascular stress test		Other	

Movement, exercise and rest:

What forms of exercise and movement do you enjoy?

_____

Please describe your usual physical activity:

Activity	How often	How long each time

How many hours of sleep do you usually get each night? _____

Describe any issues you have with sleep.

_____

_____

Nutrition: Please list any food allergies or sensitivities:

Food	Reactions	Foods	Reactions

Please list everything you ate in last 24 hours.

Morning:
Afternoon:
Evening:
Snacks:

Do you currently or have you ever had a problem with weight or eating? Yes___ No___ If yes, please describe:

_____

Are you comfortable with your relationship with food? Yes___ No___

Do you feel knowledgeable about your nutritional needs? Yes ___ No___

Who prepares your meals?

_____

Are there any types or groups of food you crave or eat a lot?

_____

Are there any types or groups of food you dislike or rarely eat?

_____

What do you drink on a typical day?

_____

What type of oil do you cook with? What spreads do you add to your food?

_____

How many servings of fruit do you eat /drink each day? _____

One serving fruit = one small piece of fruit, half cup of juice, half cup can or chopped fruit, 1/4 cup of dried fruit

How many servings of vegetables do you eat/ drink each day? _____

One serving = half a Cup of raw or cooked, 1 Cup fresh, green leafy vegetables, 1/4 Cup dried or one small piece

Are you currently on a special diet? If so, please describe.

_____

_____

Personal and Professional Development:

Current or past occupation: _____

Retired? ___ Working at home? ___ Caretaking? ___ Disabled? ___ Unemployed? ___

Are you happy with your occupation Yes ___ No ___

Why? _____

Do you anticipate any work changes in the near future? Retirement, etc.

_____

Do you have a racial/ culture heritage that is important to you?

_____

_____

Relationships:

Relationship status: _____. If married or partnered, what is your relationship length? _____

What are your living arrangements? _____

Number of children and ages: _____

Are you sexually active? Yes ____ No ____ Are you happy with your sexual life? _____

Which relationships fulfill and or empower you? _____

Who are what drains or energy? _____

Physical Environment:

Do you have specific health concerns about your current home or environment: (Quality of air, water, etc.)?

_____

Have you had hazardous environmental or occupational exposures? If yes, please describe.

_____

Spirituality:

What things or activities bring you your greatest joy and meaning? What inspires you?

_____

_____

What things create the greatest challenges for you?

_____

_____

List at least 3 major stressors in your life:

_____

_____

What makes you feel connected to the larger world? -Describe your spiritual or religious practices if any (i.e. meditation common prayer, time in nature, worship attendance, etc.)

_____

_____

If time and money were not an issue describe the things you want to do in your life.

_____

_____

Mind Body Connection:

Rate the amount of stress in your life.: ___ None ___ A Little Bit ___ Moderate
___ Quite a lot ___ Extreme

How well do you manage this stress? ___ None ___ A Little Bit ___ Moderate
___ Quite a lot ___Extreme

What are the main sources of stress in life? (Personal, professional, financial etc.)

_____

What are your health goals? What are your overall goals for improving your health in your life?

_____

_____

_____

Is there anything else that would be helpful for us to know about you?

_____

_____

_____