Charleston
Wellness Center

MEDICAL HISTORY

Today's Date: _____

Name: _____ **Birthdate:** _____ **Age:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **E-Mail Address:** _____

Gender: ☐ Male ☐ Female **Height:** _____ **Weight:** _____

How often and how much?

Do you use tobacco? ☐ Yes ☐ No _____
Do you use alcohol? ☐ Yes ☐ No _____
Do you use caffeine? ☐ Yes ☐ No _____

Doctor's Name: **Address:** **Phone:**

_____
_____
_____

Allergies: Please check all that apply.

___ penicillin ___ morphine ___ dye allergies ___ pet allergies
___ codeine ___ aspirin ___ nitrate allergy ___ seasonal (pollen) allergies
___ sulfa drug ___ food allergies ___ no known allergies other: _____

Please describe the allergic reaction you experienced and when it occurred?

_____
_____
_____

Over-the-counter (OTC) issues:
Please check all products that you use occasionally or regularly. Check all that apply.

___ Pain Reliever
___ Aspirin
___ Acetaminophen (example: Tylenol®)
___ Ibuprofen (example: Motrin IB®)
___ Naproxen (example: Aleve®)
___ Ketoprofen (example: Orudis KT®)
___ Cough suppressant (example: Robitussin DM®)
___ Antihistamine product (example: Chlor-Trimeton®)
___ Decongestant product (example: Sudafed ®)
___ Combination product (cough+cold reliever)(example: Triaminic DM®)
___ Sleep aids (exmples: Excedrin PC®, Unisom®, Sominex®, Nytol®)
___ Antidiarrheals (examples:Imodium®, Pepto Bismol®, Kaopectate®)
___ Laxatives/stool softeners (examples: Doxidan®, Correctol®, etc.)
___ Diet aids/weight loss products (example: Dexatrim®)
___ Antacids (examples: Maalox®, Mylanta®)
___ Acid blockers (examples: Tagamet HB®, Pepcid C®, Zantac 75®)
___ Other (please list)
_____

PATIENT NAME: _____

___ **Nutritional/Natural Supplements: Please identify and list the products you are using:**

- ☐ vitamins (examples: multiple or single vitamins such as B complex, E, C, beta carotene)
- ☐ minerals (examples: calcium, magnesium, chromium, colloidal minerals, various single minerals)
- ☐ herbs (examples: Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.)
- ☐ enzymes (examples: digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.)
- ☐ nutrition/protein supplements (examples: shark cartilage, protein powers, amino acids, fish oils, etc.)
- ☐ others (glucosamine, etc.)

Medical Conditions/Diseases: Please check all that apply to you.

___ Heart disease (example: Congestive Heart Failure)
___ High cholesterol or lipids (examples: Hyperlipidemia)
___ High blood pressure (example: Hypertension)
___ Cancer
___ Ulcers (stomach, esophagus)
___ Thyroid disease
___ Hormonal Related Issues
___ Lung condition (example: asthma, emphysema, COPD)
___ Blood Clotting Problems
___ Diabetes
___ Arthritis or joint problems
___ Depression
___ Epilepsy
___ Headaches/migraines
___ Eye Disease (glaucoma, etc.)
___ Other: Please list: _____

_____

_____

Current Prescription Medications:

Medication Name	Strength	Date Started	How often per day.

List Hormones previously taken.	Date Started	Date Stopped	Reason

Bone Size _____ Small _____ Medium _____ Large _____

Body Type: ☐ Androgenic ☐ Estrogenic

Have you ever used oral contraceptives? ☐ No ☐ Yes
Any problems? ☐ No ☐ Yes
If YES, describe any problem(s).

_____

_____

PATIENT NAME: _____

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How many pregnancies have you had? ____ **How many children?** _____

Any interrupted pregnancies? ☐ No ☐ Yes

Have you had a hysterectomy? ☐ No ☐ Yes (Date of Surgery) _____
Ovaries removed? ☐ No ☐ Yes

Have you had a tubal ligation? ☐ No ☐ Yes (Date) _____

Do you have a family history of any of the following?

Uterine Cancer	_____	Family member(s)	_____
Ovarian Cancer	_____	Family member(s)	_____
Fibrocystic breast	_____	Family member(s)	_____
Breast Cancer	_____	Family member(s)	_____
Heart Disease	_____	Family member(s)	_____
Osteoporosis	_____	Family member(s)	_____

Have you had any of the following tests performed? Check those that apply and note date of last test.

Mammography	☐ No	☐ Yes	Date: _____
PAP Smear	☐ No	☐ Yes	Date: _____

Since you first began having periods, have you ever had what YOU would consider to be abnormal cycles? ☐ No ☐ Yes Date: _____

If YES, please explain (such as age when this occurred, symptoms….):

_____

_____

_____

_____

_____

When was your last period? _____

How many days did it last? _____

Do you have, or did you ever have Premenstrual Syndrome (PMS)? ☐ No ☐ Yes
If YES, explain symptoms:

_____

_____

_____

PATIENT NAME: _____

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PATIENT INFORMATION SHEET

	ABSENT	MILD	MODERATE	SEVERE
Fibrocystic Breast				
Weight Gain				
Heavy/Irregular menses				
Hot Flashes				
Dry Skin/Hair				
Anxiety				
Depression				
Night Sweats				
Vaginal Dryness				
Headaches				
Irritability				
Mood Swings				
Breast Tenderness				
Sleep Disturbances/Insomnia				
Cramps				
Fluid Retention				
Breakthrough Bleeding				
Fatigue				
Loss of Memory				
Bladder Symptoms				
Arthritis				
Harder to Reach Climax				
Decreased Sex Drive				
Hair Loss				

Patient Name: _____

Charleston Wellness Center

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Folly Beach, S.C. 29439
843-588-1230

Nothing said, done, performed, typed, printed or indicated by me is intended to diagnose, prescribe or treat a disease. No statement should be interpreted as a claim or representation that any lifestyle or nutritional change constitutes a diagnosis, cure, palliative or ameliorative for any disease.

All patients are encouraged to seek competent medical attention when deemed necessary. I, Dr. Deena Fawn Smith, am a Chiropractic Physician. Chiropractic's medicinal goal is to assist the body in its own healing abilities. We attempt to ascertain certain lifestyle changes, nutritional supplements and various dietary changes that may measurably enhance or improve the patient's health and well-being. Nothing said or discovered in our work together will be released or revealed to anyone other than yourself, unless you authorize it so in writing.

It is your responsibility and right to consult with your primary physician and consult with him/her about any findings, dietary changes or nutritional supplements that are recommended to ensure that there are no interactions with your medications.

Date_____ Patient's Signature_____

Please print name_____

Address _____

_____

Telephone #'s_____

Email _____