DelVal Integrative Health Partners, LLC
Rebecca Nice, DO
Health History Intake Form

Patient Name	Date of Birth	Gender	Today's Date

Medical History – Please check if you currently have or have ever had any of the following:

Yes	No		Yes	No	
		High Blood Pressure			Cancer
		Diabetes			Hepatitis
		Heart Attack			Gallstones
		Stroke			Kidney Stones
		Mini-Stroke (TIA)			Osteoarthritis
		High Cholesterol			Rheumatoid Arthritis
		Heart Murmur			Blood Clots (DVT/PE)
		Atrial Fibrillation			Hernia
		Mitral Valve Prolapse			Bladder Infections (UTI)
		Asthma			Kidney Infections
		COPD/Emphysema			Vaginitis
		Tuberculosis			Sexually Transmitted Disease
		Seasonal Allergies			Seizures
		Eczema			Multiple Sclerosis
		Acne			Lupus (SLE)
		Irritable Bowel Syndrome			Hyperthyroid (overactive)
		Diverticulosis/Diverticulitis			Hypothyroid (underactive)
		Colitis			Anemia
		Crohn's Disease			Blood Transfusion
		Reflux/GERD			Depression
		Peptic Ulcers			Anxiety

Please list any additional illnesses or further explain above answers.

Surgical History – Please check if you have had any of the following procedures and note the approximate date.

	Procedure	Date			Hernia Repair	
	Appendectomy				Oral surgery/wisdom teeth	
	Caesarian Section				Tonsillectomy	
	Gall Bladder				Vasectomy	

Please list any additional surgeries and the approximate date.

Medications/Supplements - Please list any prescribed and over-the-counter medications along with dosages and reason for taking.

Medication/Supplement	Dose and Frequency	Reason/Diagnosis

Allergies- Please list any allergies to medical-related substances (medicines, dyes, iodine, latex, etc.)

Substance	Reaction	Substance	Reaction

Social History – Please answer the following questions.

	Yes	No		
Do you currently smoke?			If yes – daily amount	
			If yes – number of years	
If no, did you ever smoke?			If yes – quit date	
Do you currently drink alcohol?			If yes – amount and type	
			If yes – how frequently	
If no, did you ever drink alcohol?			If yes – quit date	
Do you currently use illicit drugs?			If yes – what?	
Do you have a history of illicit drug use?			If yes – quit date	
Are you sexually active?			If yes – men, women, both	
Have you ever been physically abused?				
Have you ever been verbally abused?				
Do you exercise?				

Family History – Please include parents, grandparents, sibling, and children (if applicable).

Relationship	Age	Illnesses/Conditions and Cause of Death (if applicable)

Review of Systems – Do you now have or have you ever had any of the following?

Now	Past		Now	Past	
		Fatigue			Easy Bruising
		Fevers			Easy Bleeding
		Weight Loss - Unexplained			Prolonged Bleeding
		Weight Gain – Unexplained			Indigestion
		Heat Intolerance			Nausea
		Cold Intolerance			Vomiting
		Blurry Vision			Diarrhea
		Eye Pain			Constipation
		Spots/Floaters in Eyes			Abdominal Pain
		Watery Eyes			Hemorrhoids
		Vision Change			Bloody or Dark Stool
		Earaches			Blood in Urine
		Hearing Loss			Painful urination
		Tinnitus (Ringing in Ears)			Urinary urgency
		Runny Nose			Muscle Weakness
		Snoring			Joint Stiffness
		Post Nasal Drip			Muscle Spasms
		Congestion - Nasal			Joint Pains
		Frequent Sore Throats			Rashes
		Gum Problems			Acne
		Hoarseness			Changing Moles
		Chest Pain/Discomfort			Headaches
		Palpitations			Memory Problems
		Leg Pain with Walking			Sleep Problems
		Swelling of Legs/Feet			Numbness
		Varicose Veins			Weakness
		Shortness of Breath			Dizziness
		Cough			Anxiousness
		Wheezing			Sadness
					Hallucinations
		Females Only:			Males Only:
		Nipple Discharge			Penile Discharge
		Breast Pain			Genital Lesions/Rash
		Vaginal Discharge			Testicular Pain
		Genital Lesions/Rash			

Females Only:

Are you currently pregnant?	
Are you actively trying to become pregnant?	
Are you using birth control? If so, what type?	
First day of Last Menstrual Period	

Health Maintenance – Please list the date of the most recent test.

Test	Date	Result
Mammogram		
Pelvic Exam/Pap Smear		
Testicle/Prostate Exam		
PSA Test		
Rectal Exam		
Stool for Blood		
Colonoscopy		
DEXA scan		
Dental Exam		

Any other Maintenance Testing:

Test	Date	Result

Have you ever had an abnormal screening test? If yes, when and what was done about it?

Other

Any other comments or pertinent history:
