PRAXIS HEALTH

Medical History

Patient Name ____ DOB _____________

Please select all of the illnesses that you have been treated for:

- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Fainting spells
- ☐ Frequent urinary tract infections
- ☐ Glaucoma
- ☐ Heart attack
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ None
- ☐ Kidney disease
- ☐ Lung/respiratory disease
- ☐ Memory loss/dementia
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Neurological problems
- ☐ Seizures
- ☐ Sexual disease
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Other:

Please select all of the surgeries you have undergone:

- ☐ Appendectomy
- ☐ Back/Spine
- ☐ Breast
- ☐ Cataract
- ☐ Colon or intestine
- ☐ Ear tube replacement
- ☐ Gallbladder
- ☐ Heart
- ☐ None
- ☐ Hernia
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Knee
- ☐ Prostate
- ☐ Shoulder
- ☐ Tonsillectomy
- ☐ Other:

Please indicate which family members have a history of the following conditions:

	Father	Mother	Brother	Sister	Son	Daughter
Alcoholism	☐	☐	☐	☐	☐	☐
Bleeding disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐
Mental health problems	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

PRAXIS HEALTH

Social History

Patient Name ______________________________________ DOB _____________

Marital Status: Single Married Divorced Widow Partner/Significant other

Whom do you live with? ____

Sexual Orientation (optional): Heterosexual Bisexual Same Sex Other

Gender Identity (optional): Male Female Transgender male Transgender female Genderqueer

Preferred Pronouns (optional): He/Him/His She/Her/Hers They/Them/Theirs

Current Occupation: ____

Which type of diet do you follow?

- ☐ Regular
- ☐ Low-salt
- ☐ Gluten-free
- ☐ Vegan
- ☐ Vegetarian
- ☐ Other - describe: ____________________

Do you drink caffeinated beverages? Yes No

If yes, which type? (Select all that apply)

- ☐ Coffee
- ☐ Tea
- ☐ Soda/Engery drinks
- ☐ Other - describe: ____________________

Which selection best describes your relationship with TOBACCO/NICOTINE?

- ☐ Never smoker
- ☐ Former smoker - quit date? _________
- ☐ Current smoker (select all that apply)
  - ☐ Cigarettes
  - ☐ Electronic cigarettes/vaping
  - ☐ Cigars
  - ☐ Pipe
- ☐ Fomer smokeless tobacco
- ☐ Current smokeless tobacco

Do you use marijuana? Yes No

Which selection best describes your relationship with ALCOHOL?

- ☐ 2 or less alcoholic drinks per day
- ☐ 3 or more alcoholic drinks per day
- ☐ I do not drink alcohol
- ☐ I am a recovering alcoholic

Do you use recreational drugs? Yes No

If yes, which drugs do you use?

- ☐ Amphetamines (uppers, speed, meth)
- ☐ Benzos (Xanax, Klonopin, Ativan)
- ☐ Cocaine
- ☐ Heroin
- ☐ Other - describe: ____________________

On average, how many days per week do you engage in moderate to strenuous physical activity? ___________

Are you sexually active? Yes No

If yes, what form of birth control do you use?

- ☐ None
- ☐ Birth control pills
- ☐ Condoms
- ☐ Contraceptive implant
- ☐ Diaphragm
- ☐ Injection (Depo Provera)
- ☐ IUD
- ☐ Rhythm method
- ☐ Tubes tied
- ☐ Vaginal ring
- ☐ Vasectomy
- ☐ Withdrawal method

In the past two weeks, have you been bothered by little interest or pleasure in doing things? Yes No

In the past two weeks, have you been bothered by feeling down, depressed, or hopeless? Yes No

PRAXIS HEALTH

Review of Systems

Patient Name _____________________________ DOB ___________

Which symptoms have you had in the last 2 months? (Select all that apply)

General:

- ☐ Weight gain or loss
- ☐ Fatigue
- ☐ Fever/Chills
- ☐ Night sweats
- ☐ Swollen lymph nodes
- ☐ Frequent falls
- ☐ Intolerance to heat or cold

Head:

- ☐ Headache
- ☐ Vision changes
- ☐ Nosebleeds
- ☐ Difficulty swallowing
- ☐ Trouble with ears

Chest:

- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Cough
- ☐ Snoring
- ☐ Sleep issues

Breast:

- ☐ Lump or mass
- ☐ Nipple discharge

Heart:

- ☐ Chest pain
- ☐ Leg swelling
- ☐ Irregular heart beat

Gastrointestinal:

- ☐ Nausea
- ☐ Constipation
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Black or tarry stool
- ☐ Abdominal pain
- ☐ Heartburn/Indigestion

Urinary:

- ☐ Urinary frequency
- ☐ Blood in urine
- ☐ Painful urination
- ☐ Urinary incontinence
- ☐ Unable to urinate

Musculoskeletal:

- ☐ Joint pain
- ☐ Muscle spasms
- ☐ Joint swelling
- ☐ Muscle aches

Skin

- ☐ Mole changes
- ☐ Skin rash

Social:

- ☐ Depression
- ☐ Anxiety
- ☐ Considered suicide
- ☐ Sleep disturbances
- ☐ Intententional self-injury

Sexual:

- ☐ Problem with sexual function
- ☐ Unsafe sexual practices

Neurological:

- ☐ Dizziness
- ☐ Loss of consciousness/fainting
- ☐ Weakness
- ☐ Memory loss/lapse
- ☐ Numbness

- ☐ Other - please describe:

Female Only

- ☐ Vaginal discharge
- ☐ Pelvic pain
- ☐ Irregular periods

Date of last period _________________

Number of Pregnancies? ____________

Number of Pregnancies carried to term? ________