Dr. Naomi Shields

Name: ________________________ **Date:** ___________________

DOB: ________________________

PAST MEDICAL HISTORY

PLEASE LIST ALL OF YOUR MEDICAL PROBLEMS, SUCH AS HIGH BLOOD PRESSURE OR HEART DISEASE

____

____

PLEASE LIST ALL OF YOUR PAST SURGERIES, HOSPITALIZATIONS, SEVERE INJURIES (INCLUDE DATE)

____

____

____

DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS? ____

LIST MEDICATIONS THAT YOU ARE **CURRENTLY** TAKING (INCLUDE NAME & DOSAGE)

____

____

____

SOCIAL HISTORY

WHAT KIND OF WORK DO YOU DO? ____

MARITAL STATUS: ____ SINGLE ____ MARRIED ____ DIVORCED ____ WIDOWED

DO YOU HAVE CHILDREN? ____ YES ____ NO HOW MANY? ____

WHO LIVES AT HOME WITH YOU? ____

DO YOU DRINK ALCOHOL? ____ YES ____ NO IF YES, HOW MAY DRINKS PER WEEK ____________________

DO YOU USE ILLICIT DRUGS? ____ YES ____ NO DESCRIBE: ____

DO YOU SMOKE? ____ YES ____ NO IF YES, HOW MANY PACKS PER DAY _______ FOR HOW LONG _______

DO YOU EXERCISE REGULARLY? ____ YES ____ NO DESCRIBE: ____

DO YOU FOLLOW A SPECIAL DIET? ____ YES ____ NO DESCRIBE: ______________________________________

18626 Hardy Oak, Suite 101 ♦ San Antonio, Texas 78258 ♦(210) 878-4116 ♦ Fax (210) 878-4113

Dr. Naomi Shields

FAMILY HISTORY

MEMBER ALIVE/DECEASE AGE HEALTH STATUS/CAUSE OF DEATH

FATHER: ____

MOTHER: ____

SIBLING: ____

OTHER INFORMATION:

HEIGHT ___________________ WEIGHT _________________

DO YOU CURRENTLY OR HAVE YOU EVER HAD PROBLEMS WITH ANY OF THE FOLLOWING?
(CHECK ALL THAT APPLY)

CONSTITUTIONAL

____RECENT WEIGHT LOSS

____RECENT FEVERS

SKIN

____PSORIASIS

____ECZEMA

HEMATOLOGIC/BLOOD

____BLOOD CLOTS

____ANEMIA

EYES

____WEARS GLASSES

____CATARACTS

GENITOURINARY

____PROSTATE

____KIDNEY PROBLEMS

ENDOCRINE

____DIABETES

____THYROID

EAR/NOSE/THROAT

____SINUS PROBLEMS

____ACTIVE DENTAL PROBLEMS

PSYCHIATRIC

____DEPRESSION

____SCHIZOPHRENIA

CARDIOVASCULAR

____ HEART ATTACK

____HEART MURMUR

____IRREGULAR HEART BEAT

____HIGH BLOOD PRESSURE

____HIGH CHOLESTEROL

GASTROINTESTINAL

____COLITIS

____DIVERTICULITIS

____ULCER

____ HERNIA

____LIVER DISEASE

NEUROLOGIC

____SEIZURES/EPILEPSY

____POLIO

____PARKINSONS DISEASE

____ALZHEIMERS DISEASE

____BALANCE PROBLEMS

RESPIRATORY

____ASTHMA

____BRONCHITIS

____EMPHYSEMA

____PNEUMONIA

____TUBERCULOSIS

MUSCULOSKELTAL

____RHEUMATOID ARTHRITIS

____ANKYLOSING SPONDYLITIS

____LUPUS

____OSTEOPOROSIS

CANCER

WHAT KIND/TREATMENT

____

____

____

OTHER

____

____

____

____

18626 Hardy Oak, Suite 101 ♦ San Antonio, Texas 78258 ♦(210) 878-4116 ♦ Fax (210) 878-4113

Dr. Naomi Shields

IN GENERAL, WOULD YOU SAY YOUR HEALTH IS ____EXCELLENT ____VERY GOOD ____FAIR ____ POOR

DOES YOUR HEALTH NOW LIMIT THESE ACTIVITIES?

MODERATE ACTIVITIES: MOVING A TABLE, PUSHING A VACCUM CLEANER, BOWLING OR PLAYING GOLF

____YES, VERY LIMITED ____YES, SLIGHTLY LIMITED ____ NO, NOT LIMITED AT ALL

DURING THE PAST 4 WEEKS, HAVE YOU HAD ANY OF THE FOLLOWING PROBLEMS WITH YOU WORK OR OTHER REGULAR DAILY ACTIVITIES AS A RESULT OF YOUR PHYSICAL HEALTH?

ACCOMPLISHED LESS THAN YOU WOULD LIKE? ______YES _____NO

DIDN'T DO WORK OR OTHER ACTIVITES AS USUAL ______YES _____NO

DURING THE PAST 4 WEEKS, HOW MUCH DID PAIN INTERFERE WITH YOUR NORMAL WORK, INCLUDING HOUSE WORK AND WORK OUTSIDE OF THE HOME?

_____ NOT AT ALL _____ SLIGHTLY _____ MODERATELY _____QUITE A BIT _____EXTREMELY

THE FOLLOWING QUESTIONS RELATE TO HOW YOU HAVE FELT DURING THE PAST 4 WEEKS.

HOW MAY TIEMS DURING THE PAST 4 WEEKS HAVE YOU?

FELT CALM AND PEACEFUL? ___ALWAYS____MOST OF THE TIME ____SOMETIMES ____NONE OF THE TIME

HAD A LOT OF ENERGY? ___ALWAYS____MOST OF THE TIME ____SOMETIMES ____NONE OF THE TIME

FELT DEPRESSED? ____ALWAYS ____MOST OF THE TIME ___SOMETIMES ____NONE OF THE TIME

DURING THE PAST 4 WEEKS, HOW MUCH OF THE TIME HAS YOUR PHYSICAL HEALTH OR EMOTIONAL PROBLEMS AFFECTED YOU VISITING FRIENDS, RELATIVES, ETC.?

____ ALWAYS ____ MOST OF THE TIME ____ SOMETIMES ____ NONE OF THE TIME

18626 Hardy Oak, Suite 101 ♦ San Antonio, Texas 78258 ♦(210) 878-4116 ♦ Fax (210) 878-4113