The Preventive Medicine Center of Gainesville, Inc.
HEALTH PROFILE

Name: _____**Date**: _____**Chart #**_____

DEAR PATIENT: Welcome. Our goal is simple. We wish to provide you and your family with quality health care and personal attention. Before you see Dr. Erickson, we want you to take a very important first step by letting him know something about yourself and your health. *We'd like you to fill out and return this Health Profile to us*. You may also receive a Nutritional Symptom Profile to fill out. This is an important first step we take with all new patients, and it allows Dr. Erickson to advise you on how to avoid specific health threats and heal problems you may be dealing with now. We take these Health Profiles very seriously! This is a confidential record and will be kept in this office.

Birth date_____

Place of birth_____

Highest level in school_____

Occupation_____

Marital Status_____

Hobbies_____

Habits:

Smoking (type & amount)_____

If former smoker, date quit_____

Alcohol (type & amount per week)_____

Caffeine (type & amount per day)_____

Street drugs (type & amount per day)_____

Average hours of sleep/night_____

Bowel movements per week_____

Usual weight_____

Exercise level: ☐ rare ☐ 2-3 times per week ☐ 4 or more times

Please list all Allergies (foods, drugs, environment)

_____

_____

_____

Chief Complaints:

Please list in order of importance to you the 3 pressing health concerns, symptoms or problems you are experiencing:

1. _____

_____

2._____

_____

3._____

_____

When was your last physical exam?_____

Who is your current primary care doctor?_____

Please list all hospitalizations/and or serious illness you have had and the year when these occurred: ☐ none

_____

_____

_____

Do you use magnets or sleep on a magnetic mattress?_____

Are you a vegetarian? _____

List all prescription drugs you are currently taking and how many:

☐ none

_____

_____

_____

Do you currently take a multivitamin? ☐ yes ☐ no

How many multivitamin pills or capsules do you take daily?____

Other than a multivitamin, are you taking (please √ all that apply):

☐ Vitamin C ☐ CoEnzyme Q10 ☐ Magnesium

☐ Vitamin E ☐ B-Complex ☐ Ginseng

☐ Calcium ☐ Beta Carotene ☐ L-Carnitine

☐ Garlic ☐ Gingko Biloba ☐ Saw Palmetto

☐ DHEA ☐ Melatonin ☐ Glucosamine Sulfate

☐ Chromium Picolinate Other:_____

Date of last dental exam_____

Do you have amalgams (silver fillings)? ☐ yes ☐ no

Have you had your amalgams removed? ☐ yes ☐ no

When?_____

Past Medical History: √ Box ☐ if you have ever had any of the following.

☐	Measles	☐	Tuberculosis	☐	Kidney Disease
☐	Mumps	☐	Diabetes	☐	Thyroid Disease
☐	Chickenpox	☐	Cancer	☐	Bleeding tendency
☐	Whooping Cough	☐	Polio	☐	Asthma
☐	Scarlet Fever	☐	Glaucoma	☐	Depression
☐	Diphtheria	☐	Hernia	☐	Mental Illness
☐	Pneumonia	☐	Blood or plasma transfusions	☐	Drug or alcohol problem
☐	Rheumatic Fever	☐	Back trouble	☐	Any other disease (please list):
☐	Heart Disease	☐	High or low blood pressure		
☐	Arthritis	☐	Hives or Eczema		_____
☐	Venereal Disease	☐	AIDS or HIV +		_____
☐	Anemia	☐	Mitral Valve Prolapse		_____
☐	Bladder Infections	☐	Stroke		_____
☐	Epilepsy	☐	Hepatitis		
☐	Migraine Headaches	☐	Bleeding Ulcer		

Family History: Have your parents, grandparents, siblings or children had any of the following:

		Relationship			**Relationship**
☐	Cancer	_____	☐	Stroke	_____
☐	Tuberculosis	_____	☐	Epilepsy	_____
☐	Heart Disease	_____	☐	Bleeding tendency	_____
☐	High Blood Pressure	_____	☐	Asthma	_____
☐	Obesity	_____	☐	Drug/alcohol problem	_____
☐	Thyroid Disease	_____	☐	Mental illness	_____
☐	Diabetes	_____	☐	Leukemia	_____
☐	High Cholesterol	_____	☐	Gout	_____
☐	Kidney Disease	_____	☐	Migraine Headaches	_____

	Present Age and Condition/Diseases	**Age at Death and Cause/Diseases**
Father:		
Mother:		
Siblings:		
Spouse:		
Children:		

Do you now have or have you had within the past year any of the following (Circle "no" or "yes". If uncertain, leave blank.):

General:

Weakness or paralysis.....no	yes	Change in appetite.....no	yes	Night sweats…….....no	yes
Tire easily/fatigue.....no	yes	Sensitivity to cold or heat.....no	yes	Brain fog…….....no	yes
Recent weight changes.....no	yes	Persistent fever.....no	yes		

Skin:

Skin rash…….....no	yes	Skin dry…….....no	yes	Change in color of mole…..no	yes
Hair falling out…….....no	yes	Split/brittle nails.....no	yes		

HEENT:

Gums bleed.....no	yes	Wear glasses or contacts.....no	yes	Blurred vision.....no	yes
Decrease in hearing.....no	yes	Frequent nosebleeds.....no	yes	Ringing in ears.....no	yes
Loss of smell.....no	yes	Persistent hoarseness.....no	yes	Sinus trouble.....no	yes
Sore tongue or gums.....no	yes	Bad breath.....no	yes	Sore throat.....no	yes

Respiratory-cardiovascular:

Lump in breast.....no	yes	Chronic or frequent cough.....no	yes	Shortness of breath.....no	yes
Breast discharge.....no	yes	Wheezing.....no	yes	Chest pain or discomfort.....no	yes
Leg cramps with walking...no	yes	Swelling of hands/feet/ankles...no	yes	Palpitations/fluttering of heart...no	yes
Leg cramps at night.....no	yes	Blood in sputum.....no	yes	Purple fingers/lips.....no	yes

Gastrointestinal:

Difficulty swallowing.....no	yes	Nausea.....no	yes	Chronic constipation.....no	yes
Heartburn.....no	yes	Vomiting.....no	yes	Rectal bleeding.....no	yes
Abdominal pain/cramps.....no	yes	Frequent diarrhea.....no	yes	Black tarry stools.....no	yes

Genitourinary:

Frequent urination (day).....no	yes	Leakage of urine.....no	yes	Lack of sex drive.....no	yes
Frequent urination (night).....no	yes	Difficulty in starting urine.....no	yes	Kidney stones.....no	yes
Painful or burning urination…no	yes	Blood in urine.....no	yes	Frequent bladder infections...no	yes

Musculoskeletal:

Low back pain.....no	yes	Joint pain or stiffness.....no	yes	Swollen joints.....no	yes

Neuropsychiatric:

Trouble sleeping.....no	yes	Seizures.....no	yes	Memory loss.....no	yes
Dizziness/fainting spells.....no	yes	Numbness or tingling.....no	yes	Depression.....no	yes
Severe headaches.....no	yes	Anxiety or panic attacks.....no	yes	Thoughts of suicide.....no	yes

Men only:

Discharge from penis.....no	yes	Pain or lump in testicles.....no	yes	Impotence.....no	yes

Women only:

Age period began_____		Painful periods?.....no	yes	Any itching in vaginal area?.....no	yes
How many days do periods last?_____		Do you have PMS symptoms?....no	yes	Pain with intercourse?.....no	yes
How many days between periods?_____		Date of last period_____		Type of birth control used_____	
Is the flow heavy?.....no	yes	Date of last pelvic exam_____		Number of pregnancies_____	
Spotting between periods?.....no	yes	Date of last mammogram_____		Number of full term births_____	
				Number of preterm births_____	

SIGNATURE OF PATIENT OR PARENT OF MINOR CHILD **DATE**