CONFIDENTIAL PERSONAL INFORMATION

Full Legal Name: ____/__________________________________/_______
(Last Name) (First Name) (Middle Initial)

Preferred Name:_________________Age:_______Date of Birth:_____________S.S.#:_____XXXXX________

Address:____/_____________/________/_________________
(street#/PO Box) (city) (state) (Zip code)

Telephone # _(____)______________/_(____)_____________________/_(____)___________________________
(home) (work) (cell phone orother)

E-mail address:____Gender: female______male ______

Are you (check one): Single_____Married_____Other_____Partner's Name: _________________________

Occupation:____(circle) Full time/ Part time /Student/ Retired

Employer / School: ____

Address:____________________________/_____________________/________________/_____________________
(Street / PO Box) (City) (State) (Zip code)

Emergency Contact ____
(Name) (Relationship)

_(_____)____(_____)_________________________________
(Day Phone) (Evening Phone)

What is the **best way** to communicate with you between office visits? (E-mail, Home, Work, Cell Phone).
Is there any place you do **NOT** want me to leave a message? _________________________

Please be aware that e-mail is not a secure communication and that discussion of your medical care will become part of your medical record.

May Brandi Owens, RN discuss your private medical information with you via e-mail? ◊Yes ◊ No

By signing below, I verify that the above and below information is correct and true to the best of my knowledge.

Signature of Patient____Today's Date _______________________

CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE

Name: ____Date: _____________

What are the concerns for which you are seeking care? (Primary concern first)

1. ____ Date of onset: _________________
2. ____ Date of onset: _________________
3. ____ Date of onset: _________________

Who is your primary care physician? ____
(Name) (Phone if known)

For what concern did you last receive health or medical care? ________________________________

Medications and Supplements

What medications (prescribed or over the counter), herbs, vitamins, supplements, etc. are you

currently taking? ____

____

____

Check each that you currently use:

__ Laxatives __Pain relievers __Antacids __Cortisone
__Antibiotics __Heart/Blood medication __Allergy Medication __Thyroid medication
__Sleeping pills __Anti-depressants __Birth Control Pills __Hormones

Do you have any known contagious diseases at this time? ◊ Yes ◊ No If yes, what?_____________

Family History

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Ages (if living)							
Current health							
Age at death							
Cause of Death							

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Indicate the number of relatives who have the disease.

Cancer______________________ Diabetes_____________________ Epilepsy____________________
Heart Disease ________________ High Blood Pressure ___________ Stroke______________________
Anemia_____________________ Kidney Disease _______________ Glaucoma__________________
Allergies____________________ Asthma______________________ Mental Illness ________________
Arthritis _____________________ Tuberculosis __________________ Alzheimer's Dz_______________

Name: ____ Date: __________________

Have you have any of the following Childhood Illnesses (check if yes)

Scarlet fever___Diphtheria____Rheumatic fever____Mumps____Measles___German measles ___

Have you had any immunizations? n Yes n No Negative Reactions? ________________________

Hospitalizations, Surgery, X-Ray and Special Studies

_____________________________year:_________ _____________________________year: _________

_____________________________year:_________ _____________________________year: _________

_____________________________year:_________ _____________________________year: _________

Allergies

Are you hypersensitive or allergic to foods, drugs, or environmental substances? Please list:

____

General

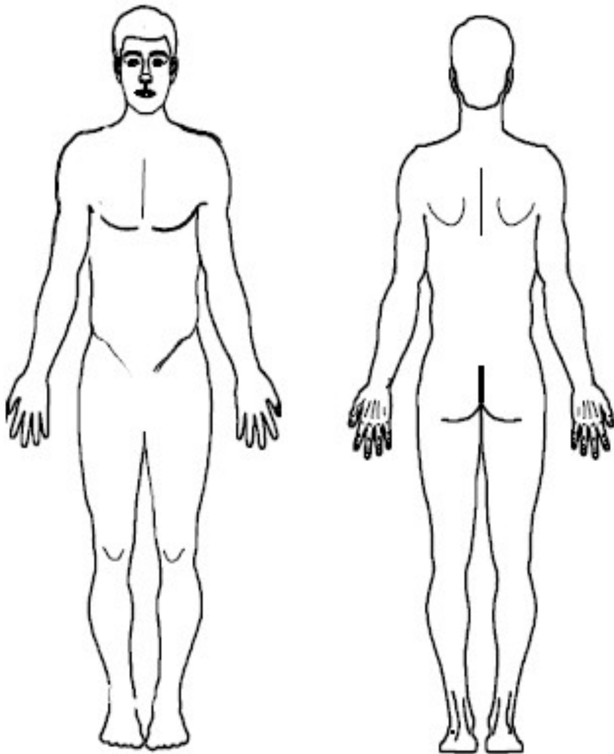
Weight ___________lbs. Height_____________ Weight 1 year ago______________lbs.

Maximum (non pregnant) Weight____________lbs. When ________________________

Review of Symptoms

Answer questions or check any of the following you have or have had in the past 6 months.

Please shade in areas where you are experiencing pain on figures (if applicable).



LIFESTYLE HABITS

Main interests and hobbies? __________
Exercise, what kind? _______________
How often do you exercise? ____________
__Y __ N Have a religious/spiritual practice
__Y __ N Average 6-8 hrs. of sleep
__Y __ N Have a supportive relationship
__Y __ N History of abuse
__Y __ N Major traumas
__Y __ N Use recreational drugs
__Y __ N Treated for drug dependence
__Y __ N Drink coffee
__Y __ N Drink black or green tea
__Y __ N Drink cola or other sodas
__Y __ N Add salt to your food
__Y __ N Eat refined sugar
__Y __ N Enjoy your work
__Y __ N Take vacations
__Y __ N Spend time outside
__Y __ N Watch TV? How much? ______
__Y __ N Read? How often? __________
__Y __ N Use alcoholic beverages
per week _____
__Y __ N Treated for alcoholism
__Y __ N Use tobacco currently
__Y __ N Used tobacco in the past
How many years? ___ Packs per day?___

Name:____Date:__________________

Context of Care Overview

I would like to take a moment to welcome you to my practice. Whether you are here for a one-time visit, or are looking for a longer-term comprehensive health solution, I look forward to my role in your care. Below are a few questions that really assist me in understanding you better and how I can best support your health.

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% **0 1 2 3 4 5 6 7 8 9 10** 100%

If you answered less than "10", what stands between your current commitment and 100%?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that I will be sharing with you?

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

What do you love most about your life at this time?

Lymphedema Evaluation Form

Name: ___________________________Date: __________

1. How long have you had lymphedema? _______________
2. Have you ever had any lymphedema infections? ___________
3. Do you ever leak fluid? _____________________________
4. Do you take Prophylactics antibiotics? __________________
5. Do you take diuretics for lymphedema? _________________
6. Do you take benzopyrones for lymphedema? _____________
7. Do you take any other drug for lymphedema? _____________
8. Does anyone in your family have lymphedema? ___________
9. Which extremity has lymphedema?

(Check all that apply) Left Arm _____ Right Arm_____

Left Leg ______ Right Leg _____

10. Have you had prior treatment for lymphedema?

(Check all that apply) Surgery ____Compression Garment____

Antibiotics_____ Pneumatic Pump_____ Manual Lymph Drainage ________Did this include rerouting?___________________

11. Do you have bronchial asthma? ______________________
12. Do you have hypertension? __________________________
13. Do you have diabetes? _____________________________
14. Do you have allergies? _____________________________
15. Do you have any cardiac problems? _______If yes, please describe____
16. Do you have any kidney problems? ________If yes, please describe____
17. Do you have any circulatory problems? ________If yes, please describe____
18. What medication(s) are you currently taking? _____________ _________________ _____________________________________
19. Have you ever had radiation therapy? ________If yes, date____________ Location(s)_________________________________
20. Have you ever-received chemotherapy? _________If yes, date____________

Length of time, and how many rounds____

21. What operation(s) have you had? ____
22. Who referred you to our facility? ____________________________________

Name:____

Address: _______________________________________

Phone: (_____)__________________________________

23. Can we write to or discuss your lymphedema problem with your physician if needed? YES________NO________
24. If you are treated at this office, you will be asked to continue your current maintenance program at home.

This consists of, but not limited to:

a)Elastic sleeve or stocking worn during the day.

b)Bandaging of limb over night, if you have been taught how to do this.

c)Meticulous skin care to avoid infections.