Elite Care Wellness
Vicken Poochikian, M.D.

# MEDICAL HISTORY FORM

**Name** ____________________________________________ **Date**________________

**Please check ANYTHING and EVERYTHING that applies to you. IT WILL BE MORE BENEFICIAL FOR YOUR CARE.**

**1**. Ethnic Group : Caucasian African American Asian Hispanic American Indian
Other (please specify):_______________________________

**2.** Current Marital Status: Single Married Divorced Separated Widowed

If married, how long ? ________________________ If divorced, how long ? _____________________

**3.** Children: Number, total: ____ Number, girl(s)_________ Number, boy(s)____________

**4.** What are your two primary medical reasons for seeking consult

When did you last feel well (absent of all symptoms)?______________________________________

**Reason 1** (explain):__________________________________ Date symptoms started:___________

Date symptoms first occurred:____________________ Frequency of symptoms:_________________

What makes condition improve?________________________________________________________

What makes condition worse?__________________________________________________________

Do you think this problem will resolve itself? Yes No

Previous Treatments: Treatment Outcome:

___________________________________________________ ______________________________

___________________________________________________ ______________________________

Reason 2 (explain):_____________________________________________________________________

Date symptoms first occurred:____________________ Frequency of symptoms:___________________

What makes condition improve?__________________________________________________________

What makes condition worse?____________________________________________________________

Do you think this problem will resolve itself? Yes No

Previous Treatments : Treatment Outcome:

| Previous Treatments | Treatment Outcome |
|---|---|
| ______________________________ | ______________________ |
| ______________________________ | ______________________ |

**5.** Who suggested that you seek consult

Self Referring medical Professional My Family Friend Insurance

**6.** Significant birth events:

Premature Birth? Yes No If yes how many days premature? ___________

**7.** List all childhood illnesses (continue on reverse if necessary):

| Illness | Date(s) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**8.** List all surgeries (continue on reverse if necessary ):

| Procedure | Date(s) |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**9.** List all injuries, including motor vehicle accidents and workmen`s compensation ( continue on reverse if necessary)

| Procedure | Date(s) |
| --- | --- |
| ______________________________ | __________ |
| ______________________________ | __________ |
| ______________________________ | __________ |
| ______________________________ | __________ |
| ______________________________ | __________ |
| ______________________________ | __________ |

**10.** Have you been diagnosed with any of the following (in past or current medical condition):

| | | |
| --- | --- | --- |
| ( ) Heart disease | ( ) Kidney problem | ( ) Stroke |
| ( ) Seizure disorder | ( )Thyroid problems | ( ) Arthritis |
| ( ) High blood pressure | ( ) Glaucoma | ( ) Diabetes |
| ( ) Obesity | ( ) High cholesterol | ( ) Ulcers |
| ( ) Periodontal disease | ( ) Oral gum/bone problem | ( ) Cancer |
| ( ) Whiplash | ( ) Liver disease | ( ) Cataracts |
| ( ) Depression | ( ) Manic depressive disorder | |

( ) Other (please list): ______________ ______________

______________ ______________ ______________

**11.** List any other medical conditions you have had, and dates (do not include common cold or flu):

| Illness | Date(s) |
| --- | --- |
| ______________________________ | __________ |
| ______________________________ | __________ |
| ______________________________ | __________ |
| ______________________________ | __________ |

**12.** How often do you get a cold? ______________________________

**13.** If your family has a history of any of the following, please:

a. Circle the condition and

b. Write "F" for father, "M" for mother, and "S" for sibling within the parentheses:

( ) Heart disease | ( ) Kidney problem | ( ) Stroke

( ) High blood pressure | ( ) Diabetes | ( ) Cancer

( ) Depression | ( ) Obesity | ( ) Schizophrenia

( ) Early senility | ( ) Manic depressive disorder | ( ) Alcoholism

( ) Seizure disorder | ( ) Other: ____________________ ____________________

____________________ ____________________ ____________________

**14.** List known allergies (including to medications): No known allergies

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

**15.** List All medications, prescription and over-the-counter, you are now taking.

| Prescription Medication | Dosage |
|---|---|
| | |
| | |
| | |

**16.** List medications, prescription and over-the-counter, you have taken in the past. Please note the length of use (continue on reverse if necessary):

| Prescription Medication | Dosage | Dates |
|---|---|---|
| | | |
| | | |
| | | |

**17.** List all supplements/alternative remedies (vitamins, minerals, herbs, etc.) you are now taking and/or alternative treatments you are undergoing. Attach a separate sheet if necessary :

| Supplement/Alternative Treatment | Size(mg, mcg, etc.) | Daily Dose |
|---|---|---|
| ________________________ | __________ | ________ |
| ________________________ | __________ | ________ |
| ________________________ | __________ | ________ |
| ________________________ | __________ | ________ |

**18.** List all immunization you have received:

______________ ________________ ______________

______________ ________________ ______________

19. List any handicaps or impairments (such as hearing or vision loss):

______________ ________________ ______________

______________ ________________ ______________

**20.** List travel from the past two years :

| Destination | Date(s) |
|---|---|
| ______________________________________ | __________ |
| ______________________________________ | __________ |
| ______________________________________ | __________ |
| ______________________________________ | __________ |

***ALLERGY:***

**21.** Have you had any of the following types of allergy? Yes ( ) No ( )

Please circle which one: Cytotoxic, Rest, Intradermal (Rinkel), Scratch, Other________

**22.** Are you allergis to any foods? ( ) Yes ( ) No If so, which ones:

____________________________________ ____________________________________

____________________________________ ____________________________________

____________________________________ ____________________________________

**23.** Do you have inhalant allergies? Yes ( ) No ( ) In past ( ) Trees ( ) Grasses( )

Molds ( ) Dust ( ) Smoke ( ) Other ( ) _________________________________

**24.** List other allergies you have ________________________________________________________

**25.** Have you ever had serious allergic reaction? Yes ( ) No ( )

If yes, to what? __________________________________________________________________

Give approximate date and symptoms:_______________________________________________

What treatment did you receive? ____________________________________________________

**26.** Do you have a chronic sniffle or cough? Yes ( ) No ( )

***ASTHMA RESPIRATORY DISEASE:***

**27.** Do you have Asthma? Yes ( ) No ( ) In Past ( ).

If yes, Slight ( ) Moderate ( ) Significant ( ).

**28.** Have you been treated for Asthma? Yes ( ) No ( )

**29.** Have you tried nutrition? Yes ( ) No ( )

**30.** Have you had allergy testing to document the cause of your Asthma? Yes ( ) No ( )

**31.** Have you had pulmonary function tests? Yes ( ) No ( )

**32.** Do you have chronic cough? Yes ( ) No ( )

**33.** Do you have phlegm? Yes ( ) No ( )

**34.** Do you have trouble breathing? Yes ( ) No ( )

## *DIET AND EATING DISORDER :*

**35.** Do you have a history of weight problem? Yes ( ) No ( )

Type ______________________________________________________________

**36.** Have you gained or lost 10 % or more of your normal weight in a period of one year?

Yes ( ) No ( ). Gained # of pounds__________ Lost # of pounds_____________

**37.** Do you follow a special diet? Yes ( ) No ( ) In past ( ) High Protein ( )

High complex carbohydrate ( ) Typical American ( ) Macrobiotic ( ) Ethnic ( )

Vegetarian ( ) Other ( ) ________________________________________________________

( ) Diabetes
( ) Kaposi's Sarcoma
( ) Tattoos
( ) Endocrine Disorders
( ) Keloid Scars
( ) Thyroid Disease
( ) Gold Therapy
( ) Lupus Erythematosus
( ) Vitiligo
( ) Heart Disease
( ) Permanent Makeup
( ) Herpes
( ) Precocious Puberty
( ) Psoriasis
( ) High Blood Pressure

( ) Other ______________________________________________________________

( ) Surgery in the area to be treated ? If "Yes" please explain

______________________________________________________________

***I confirm that the answers to the questionnaire are true and correct. I also confirm that that consultant has clarified any questions I did not understand.***

Name of Patient: ________________________________________ Date:____________________

Signature of Patient :_____________________________________

Name of Legal Representative: ______________________________ Date:____________________

Signature of Legal Representative :_____________________________