Dr. James Skeen

2511 Neudorf Rd., Suite F
Clemmons, NC 27012

PATIENT HISTORY FORM

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT

Date:_____

Name_____ Date of Birth: __/___/___ Phone:_____

Address: _____ __ City_____ State_____Zip_____

_____Weight:_____Height:_____Gender _____

Retail Pharmacy (Name & Number) _____

Compound Pharmacy (Name & Number) _____

Allergies: Food, Pollens, Odors, Medicines. Pets

_____

_____

TELL US ABOUT YOURSELF:
Home situation (circle, or add in writing):

Single___ Married (how long ___) Divorced (how long_____) Widowed (how long_____) Domestic partnership_____
Children? ____ Are they healthy? _____

Employment:
Status: (full-time)____part-time___ retired____disabled___
homemaker___**Occupation**_____

Lifestyles / Self-Care:

Do you smoke? No_____ Yes_____ If yes, how many packs per day? _____
If you have quit, how long ago? _____
Do you use alcohol? No_____ Yes_____ If yes, how often do you drink? _____
If you have quit, how long ago? _____
Do family or friends worry about your alcohol intake? _____
Have you ever had problems with drug use? _____
Do you drink caffeinated beverages? No ____ Yes ____What kind? _____How much_____
Do you manage Stress Well? No _____ Yes _____ Not Sure _____ Need Hel
Do you exercise regularly? No _____ Yes _____ If no, why? _____
Do you allow time to unwind and relax? No _____ Yes _____ If no, Why? _____
Do you sleep soundly? No ____ Yes ____ How many hours? _____ Falling asleep ____ Staying asleep _____

Are you satisfied with your sex life? No ____ Yes____ If no, Why? _____

Is your diet healthy enough? No _____ Yes _____ Not Sure_____ Need Help _____

Toxicity Screening

Where did you grow up? _____ Did you live near power plants, substations, or factories? _____

Are you sensitive to smells, colognes, or medication? ____ Do you have amalgam fillings? _____

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Do you cook with aluminum pans? _____ Do you have well water? _____ How long? _____

Do you live in a home that has been flooded? _____Condensation on windows? _____ Mold? _____

Do you have sinus issues? _____Shortness of Breath? ____ Do you use artificial sweeteners? _____

Do you crave Chocolate? _____ Fats? _____ Carbs (bread)? _____ Sugar? _____

Do you feel better in am _____ or pm_____?

Main Problems/reason for visit /diagnosis

Past History (illness, injury, hospitalization, surgery, and/or trauma)

FAMILY HISTORY:

Place an "X" in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Conditions	grandparents	Father	Mother	Brother	Sister	Son	Daughter	other
Allergies								
Alzheimers								
Anemia								
Cancer								
Breast Cancer								
COPD								
Depression								
Diabetes								
Heart disease								
High blood pressure								
IBS								
Psychiatric illness								
Genetic (inherited) disorder								
Kidney disease								
Liver Disease								
Migraines								
Stoke								
Ulcers								

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MEDICATIONS:

Prescription medications	Dose	How often taken

NON-PRESCRIPTION (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.)

Over-the-counter medications	Dose	How often taken

HERBAL PREPARATIONS

Herbal preparation	Dose	How often taken

Symptom Review

Digestion and Intestines
___ poor appetite
___belching/flatulence
___heartburn/ulcer
___nausea
___diarrhea
___cramping bowels
___food allergies
___abdominal pain
___indigestion
___trouble swallowing
___diarrhea
___constipation
___change in bowel habits
___nausea or vomiting
___rectal bleeding or blood in stools, itching
___abnormal liver tests

Cardiovascular
___chest pain
___history of angina or heart attack
___history of high blood pressure
___history of irregular beat
___history of poor circulation
___fainting
___swelling feet
___blood clots
___varicose veins

Pulmonary/lungs
___shortness of breath
___wheezing or asthma
___repeated colds/flu

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Muscles, Bones & Joints
___neck pain
___back pain
___muscle pain
___painful joints R_____ L _____
___shoulder
___elbow
___hip
___knee
___ankle
___wrist
___fingers
___joint swelling
___muscle weakness
___muscle cramps
___swelling of ankles or legs

Eyes, Ear, Nose & Throat
___eye pain
___blurred vision
___poor vision day
___poor vision night
___history of poor circulation
___wear corrective lenses
___swelling feet
___near sighted ___far sighted
___history of glaucoma or cataracts
___loss of hearing
___ringing in ears
___sinus problems
___hoarseness
___trouble with taste/smell
___ear aches/infections
___sneezing/discharges
___tongue discoloration
___bad breath
___teeth problems
___grinding teeth
___tonsillitis/adenoids
___facial pain
___sore throat
___ulceration tongue
___gum bleeding

Nerves, Movement, Brain
___history of stroke
___blackouts or loss of consciousness
___seizures
___nerve pain
___poor balance
___poor coordination
___tremors or shaking headaches

Urine, Kidney, Bladder
___painful urination
___wake up to urinate
___ kidney stones
___loss of control
___frequent urination
___sudden urging
___ blood/pus urine
___ urine infection UTI

Skin, Hair
___psoriasis
___warts
___ freckles
___ itching, hives
___ hair loss
___ dry skin, eczema

PLEASE BE SURE TO BRING THIS COMPLETED QUESTIONNAIRE TO YOUR APPOINTMENT