Jackson Friedman DO PLLC, 8079 Kula Hwy, PO Box 840, Kula, HI 86790 808-354-1698

Adult Health Summary

Name:	Date:	Date of Birth:
Home ph:	May I call you at this number? ☐ Is it OK to leave a message? ☐	Age:
Work ph:	May I call you at this #? ☐ Is it OK to leave a message? ☐	
Cell ph:	May I call you at this number? ☐ Is it OK to leave a message? ☐	
e-mail:	Social Security #:	
Address:		
City, State, Zip:		
Occupation		
Marital Status:		
Name of significant other:		
Spiritual practice:		
Who may we thank for referring you to our office?		
Name & Phone # of your Primary Care Physician:	Date of last Physical Exam:	

History of Present Illness:
Please describe your problem in as much detail as possible. Include:

What your primary symptoms are—

Describe the discomfort or malfunction. Include:
Location (precisely where):

Description of sensations (dull, achy, sharp, stabbing etc):

Severity on a 1 to 100 scale:

When did your symptoms begin, date and time?

What makes it **better?**

What makes it **worse?**

How often do you have your symptoms?

How long do your symptoms last when you get them?

Treatments tried and their effect on your problem --

All health care providers seen for this problem, the **diagnosis** they gave you, tests or x-rays done (results if known), and treatment given—

What is your goal for this treatment, and long term goals?

Past Medical History

Please put an "**X**" to the left of things you have had in the past. ***Write in the year*** the condition started to the right of them.
Put a "**C**" in the box for conditions you are currently experiencing.

	AIDS		Congestive Heart Failure		HIV positive		Psychiatric care
	Alcoholism		Depression		Joint replacement		Reflux
	Anemia		Diabetes		Kidney or Liver disease		Rheumatic Fever
	Anorexia		Drug Dependent		Lyme Disease		Rheumatoid arthritis
	Anxiety		Emphysema		Measles		Scarlet fever
	Appendicitis		Epilepsy		Migraines		Scoliosis
	Arthritis		Glaucoma		Miscarriage		Sexually transmitted disease
	Asthma		Gonorrhea		Mononucleosis		Stroke
	Bleeding Disorders		Gout		Multiple Sclerosis		Suicide attempt
	Blood in urine		High blood pressure		Mumps		Suicide thoughts
	Breast Lump		Heart murmur		Panic Attacks		Thyroid problems
	Bronchitis		Hepatitis		Pacemaker		Tonsillitis
	Bulemia		Hernia		Parkinson's		Tuberculosis
	Cancer		Herpes		Pneumonia		Ulcers
	Cataracts		Hiatal Hernia		Polio		Unconsciousness
	Chicken Pox		High Cholesterol		Prostate Problem		Vaginal Infetions
	Coma				Post Partum Blues		

Past Surgeries/Procedures (Include Dental—ex. Root canal, teeth pulled)

Surgery	**Date**

Birth/Trauma History/Injuries—Check (**Y/X**) any box which apply and explain circumstances and when occurred.

	Were you born by a Vaginal delivery?		Were you born by a c-section?
	Motor vehicle accident—when and injuries		
	Fall—if so, when, how high,, and injuries		
	Other trauma/injuries:		

Social History—Check (**X**) any box that applies

	Alcohol—	# drinks/day or week:	If you quit, indicate the year:
	Cigarette--	# packs/day or week:	If you quit, indicate the year & total # years you smoked:
	Recreational drug use		

Medications/Herbals/Supplements—dose and frequency, when started

Medication (dose & frequency	**Start Date**

Allergies—List any **medication**s, foods, environmental allergies and your reaction.

Family History: Present **Age** of parents now, or **age** when they died, cause of death, & their health issues, if any.

Mother_____ **Father**_____

If any blood relative has suffered from any of the following, please check (**X**) the box and indicate the relative

	Allergies		Cancer—what type?		Heart disease
	Asthma		Diabetes		High blood pressure
	Anemia		Epilepsy/Seizure		Kidney/bladder problems
	Arthritis		Glaucoma		Mental Illness
	Alcoholism		Gout		Stroke
	Blood Clotting Problems		Headaches/migraines		Other:

Consultants--Please list other practitioners you see—other physicians, chiropractors, acupuncturist etc and phone #

Review of Systems

Put an "**X**" by things you have had in the past.
Put a "**C**" for conditions you are currently experiencing.

	General		**Cardiac/vascular**		**GU**		Hair falling out
	Fever		Chest pain		Bladder control		Excessive thirst
	Chills		Chest pressure		Blood in urine		**Heme/lymph**
	Night Sweats		Fainting		Decrease force or urine		Easy bruising
	Weight Loss		Heart murmur		Painful intercourse		Bleeding gums
	Fatigue		High blood pressure		Painful urination		Lymph nodes
	Loss of energy		Irregular heart beat		Pelvic pain		**Allergies/Immun**
	Loss of sleep		Leg pain when walk		Sexual dysfunction		Seasonal allergies
	Eye		Lightheaded		Urinary hesitancy		Other allergies
	Blurred vision		Low blood pressure		**Neurology**		**Diet--# servings/day**
	Double vision		Pass out		Cold or numb hands/feet		Water
	Crossed-lazy eye(s)		Palpitations		Convulsions (seizures)		Soda
	Eye pain		Phlebitis		Frequent headaches		Coffee
	Loss of vision		Poor circulation		Muscle weakness		Tea
	Visual Flashes		Shortness of breath		Numbness/tingling		Meats
	Visual Halos		At rest		Tremors		Chicken
	Had laser surgeries		With exertion		Unsteady walking		Fish
	Wear glasses or contacts		Lying flat		Vertigo/spinning		Breads/Cereal
	Ear, Nose, Throat		Swollen ankles		**Psychosocial**		Dairy products
	Decreased hearing		Varicose Veins		Anxiety		Fruits
	Earache		**Pulmonary**		Depression		Fruit juice
	Ear discharge		Cough		Nervousness		Vegetables
	Ear fullness		Wheezing		**Skin/breast**		**Female only**
	Ear infections		**Gastrointestinal**		Eczema		# of pregnancies
	Ear ringing-buzzing		Abdominal pain		Hives		# of live births
	Hoarseness (prolonged)		Black stools		Itching		# of miscarriages/abortions
	Jaw Clicking		Bloating		Rashes		# vaginal deliveries
	Jaw locking		Blood in stools		Yellow skin/eyes		# C-sections
	Nosebleeds		Constipation		Breast lumps		Method of birth control
	Post nasal drip		Diarrhea		Nipple discharge		Periods are:
	Sinus problems		Heartburn		**Endocrine**		Regular
	Sore throat (frequent)		Hemorrhoids		Excessive weight gain		Irregular
	Swallowing difficulty		Nausea		Excessive weight loss		Painful
			Vomiting		Heat intolerance		Heavy
					Cold intolerance		Scant

Height: Weight:
Exercise practice:

Specialist Consults:

Orthopedist:
Ob/Gyn:

Last Mammo, Pap:

Urologist:

Gastrologist: