Daniel A. Shadoan, D.O. Matthew A. Gilmartin, M.D.
2299 Post Street, Suite 308 San Francisco, CA 94115
voice/text: (415) 255-5729 fax: (415) 947-7797

Please fill out as much as possible of your contact information and medical history. Read and sign the HIPPA agreement, and in addition, the Medicare agreement if you are over 65. You can bring them with you to your initial appointment, or fax or mail them back to us beforehand if you prefer. Thanks!

Registration Information

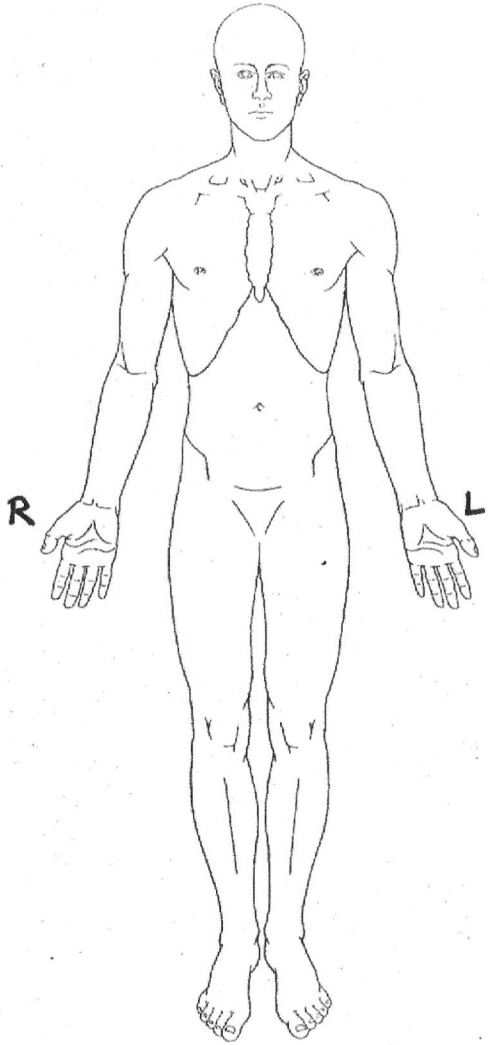
Please Print

Date: _____
Name: _____
Address:_____
City: _____Zip Code:_____
Birth Date:_____Sex:_____
Occupation:_____
Emergency Contact including Phone Number:_____

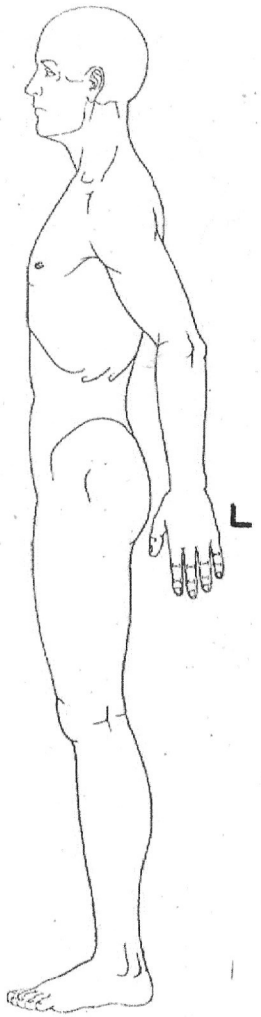
Indicate best number to reach you for confirmations or cancellations:
☐Cell:_____ ☐Home tel:_____
☐Work Phone:_____

Email:_____

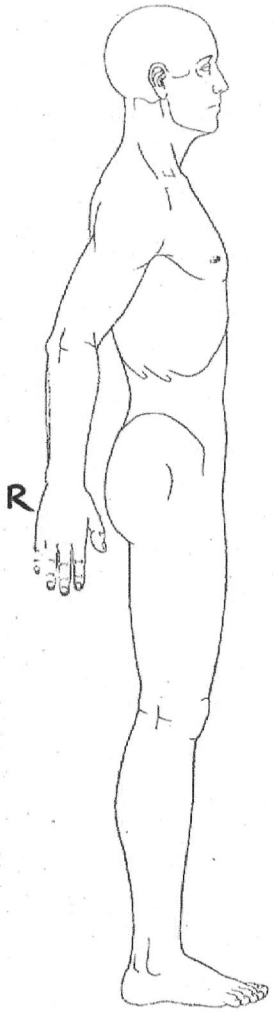
Which do you prefer for appointment confirmations: ☐ text or ☐ voice message?



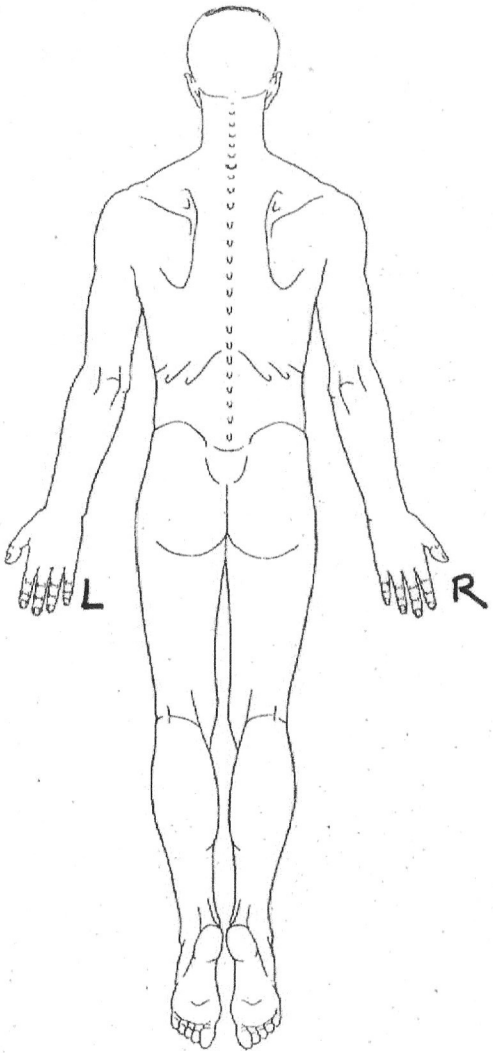
Front



Left Side



Right Side



Back

Please mark areas of pain/concern with an X.

Circle any areas of numbness/tingling.

HEALTH QUESTIONNAIRE

NAME_____ TODAY'S DATE____/____/____ Referred by? _____

BIRTHDATE____/____/____ AGE_____SEX_____

Please let us know if this is related to a motor vehicle collision, personal injury case or Medicare.

Please list the present health concerns, symptoms, or problems and reason for visit, in order of importance.
You may include a brief timeline on the back if your current problem is complex:

_____
_____
_____
_____
_____

Please list all medicines you are currently taking (include non-prescription drugs and supplements/herbs):

_____
_____
_____
_____

Please list all allergies (drugs, foods, environmental):

_____
_____

Please list all therapies and treatments you have tried (conventional and alternative):

_____
_____
_____
_____

Primary Care Physician and other Physician Specialists you see regularly or have seen in the past 5 years:

_____
_____
_____

List all major medical problems/illnesses, surgeries, including major dental work and hospitalizations, and indicate year these occurred (continue on back if necessary):

_____
_____
_____
_____
_____
_____

Describe all car accidents, injuries, head injury, falls, fractures or broken bones (include year occurred):

_____
_____
_____
_____
_____

YOUR OWN BIRTH HISTORY (as much as possible)
Please Circle: Full-Term Premature Late Vaginal Delivery Cesarian Section Forceps/Vacuum
Number of Older Siblings_____ Number of Younger Siblings_____ Birth Weight _____
Complications/Interventions:_____

SOCIAL AND DIET HISTORY
Occupation(s)_____ Marital status_____# of Children_____
Exercise/Recreation/Hobbies_____
Significant Sources of Stress_____
Habits: Smoking (type & amount per day)_____If ex-smoker, date quit_____
Alcohol (amount per week)_____ Caffeine (type & amount per day)_____
Sodas per week ____ diet or regular Other drugs (type & amount per day)_____
Dietary Restrictions/Preferences_____
Glasses of water per day _____ Date of Last Dental Exam_____

CARDIAC PROFILE check all that apply
Sex: M☐ F ☐ Age: _____ Family History of Heart Attack or Stroke: Females Under Age 60 ☐ Males Under Age 55 ☐
Do You: Smoke: ☐ Exercise Less Than 3 Times per Week: ☐ Eat Less than 4 Servings of Fruit and Vegetables per Day: ☐
Do You Have: High Blood Pressure: ☐ Diabetes ☐ Heart Disease ☐
What is your: Height _____ Weight _____ (Your ideal weight_____)
What are your most recent Cholesterol Labs (if you know): LDL: _____ HDL: _____ Triglycerides: _____

OSTEOPOROSIS RISK FACTORS check all that apply
Small/thin frame ☐ Caucasian/Asian ☐ Broken bones in adulthood ☐ Postmenopausal ☐ Early/Induced Menopause ☐
High doses thyroid medicines ☐ Steroids longer than 3 months ☐ Chemotherapy/Immunosuppressive medicine ☐
Sedentary Lifestyle ☐ Smoke ☐ Drink >4 Alcoholic Beverages per Week ☐

PAST MEDICAL HISTORY
Check any of the following conditions you have had:

Pneumonia	☐	Tuberculosis	☐	Lyme Disease	☐	Ulcer	☐
Rheumatic Fever	☐	Diabetes	☐	Asthma	☐	Kidney disease	☐
Heart Disease	☐	Cancer	☐	Hives/Eczema	☐	Thyroid Disease	☐
Arthritis	☐	Polio	☐	AIDS or HIV+	☐	Bleeding Tendency	☐
Anemia	☐	Glaucoma	☐	Infectious Mono	☐		
Bladder Infections	☐	Hernia	☐	Bronchitis	☐		
Seizures	☐	Back trouble	☐	Mitral Valve Prolapse	☐		
Migraines	☐	High/low Blood Pressure	☐	Stroke	☐		
		Hemorrhoids	☐	Hepatitis	☐		

FAMILY HISTORY
Has any blood relative had any of the following: (leave blank if no):

	Relative		Relative
Cancer	_____	Depression	_____
Tuberculosis	_____	Psychosis	_____
Diabetes	_____	Suicide	_____
Heart disease	_____	Leukemia	_____
Hypertension	_____	Migraines	_____
Stroke	_____	Obesity	_____
Epilepsy	_____	Thyroid Disease	_____
Allergies	_____	Ulcer	_____
Anemia	_____	High Cholesterol	_____
Bleeding Tendency	_____	Kidney Disease	_____
Asthma	_____	Glaucoma	_____
Chronic Lung Disease	_____	Gout	_____
Substance Abuse	_____		

List the Present Age of each of the following members of your family, and if their health is good, fair, or poor.
If deceased, list the cause of death and age.

Father_____
Mother_____
Brother(s)_____
_____
_____
Sister(s)_____
_____
_____

Son(s)_____
_____
_____
Daughter(s)_____
_____
_____
Spouse_____

Systems Review:
Circle if you now have or have had these symptoms within the past year, or if you have ever had a severe case in the past:

Weakness or Paralysis occasionally often
Tire easily occasionally often
Weight Change occasionally often
Change in Appetite occasionally often
Sensitivity to:
! Cold ! Heat occasionally often
Persistent Fever occasionally often
Night sweats occasionally often
Hot flashes occasionally often
Skin rash occasionally often
Skin problems occasionally often
Change in: ! Nails
! Hair occasionally often
Headaches occasionally often
Easy bleeding occasionally often
Easy bruising occasionally often
Double vision occasionally often
Blurred vision occasionally often
Eye pain occasionally often
Infected eyes occasionally often
Do you wear
! Glasses
! Contacts occasionally often
Last eye exam _____
Ringing in Ears occasionally often
Discharge From ears occasionally often
Ear pain occasionally often
Hearing loss occasionally often
Frequent nose bleeds occasionally often
Frequent colds occasionally often
Sinus problems occasionally often
Loss of smell occasionally often

Persistent Hoarseness occasionally often
Sore throat occasionally often
Sore tongue Or gums occasionally often
Breast lump or Discharge occasionally often
Chronic cough occasionally often
Shortness of Breath occasionally often
Bloody sputum occasionally often
Wheezing occasionally often
Chest pain or Discomfort occasionally often
Purple fingers Or lips occasionally often
Swelling of hands Feet or ankle occasionally often
Difficulty Breathing occasionally often
Palpitations or Fluttering of Heart occasionally often
Leg cramps occasionally often
Enlarged veins occasionally often
Difficulty Swallowing occasionally often
Heartburn occasionally often
Frequent Belching occasionally often
Abdominal Cramping occasionally often
Nausea occasionally often
Vomiting occasionally often
Vomited or Coughed up Blood occasionally often
Chronic Diarrhea occasionally often

Chronic Constipation occasionally often
Rectal bleeding occasionally often
Black tarry Stools occasionally often
Dark urine occasionally often
Yellow jaundice occasionally often
Frequent (day) Urination occasionally often
Frequent (night) Urination occasionally often
Increase in Thirst occasionally often
Painful Urination occasionally often
Leakage of Urine occasionally often
Difficulty Starting Urine occasionally often
Blood in urine occasionally often
Lack of sex Drive occasionally often
Hemorrhoids occasionally often
Backaches occasionally often
Joint pain or Stiffness occasionally often
Swollen joints occasionally often
Muscle cramps Or spasms occasionally often
Sleeplessness occasionally often
Seizures occasionally often
Depression occasionally often
Memory loss occasionally often
Poor Coordination occasionally often
Dizziness occasionally often
Fainting occasionally often

Men only:
Discharge from Penis occasionally often
Pain or lump In testicles occasionally often
Impotence occasionally often

Women only:
Age period began_____
# of days period lasts_____
Days between periods_____
Date of last period_____
Is your flow Heavy? occasionally often
Pain/Cramps? occasionally often
Bleeding or spotting between periods? occasionally often
Date of last pelvic_____
Abnormal Pap (when?) _____
Date of last Mammogram_____
Any itching in the Vaginal Area occasionally often
Pain with Intercourse occasionally often
Type of Birth Control used_____
Number of pregnancies_____
Number of full term Births_____
Number of preterm Births_____
Number of miscarriages ____
Number of abortions ____

Date of Most Recent:
Routine Labs _____ Chest X-Ray _____ EKG_____ Cardiac Stress Test_____ Colonoscopy _____ DEXA ____
Indicate any abnormal results: _____

Other Exams:
Saliva/Urine Hormone Testing ☐
Hair or Urine Analysis for Heavy Metals ☐
Digestive Function/Stool Analysis ☐
Neurotransmitter Testing ☐

Imaging/X-Rays: (Body Region and Reason for test)
X-ray _____
MRI _____
CT Scan _____
Sonogram _____

Other Procedures _____(on back if necessary)

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my health. I also authorize the healthcare providers to perform the necessary health care services I may need, including Osteopathic Manipulation.

Signature_____Date_____