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**info@do-sf.com • www.do-sf.com**

Please fill out as much as possible of your contact information and medical history. Read the [HIPPA/Privacy](#) agreement. You will need to sign the Medicare Agreement if applicable in the office and you may read it in advance on our website [here](#). Once you fill out this form and print it to PDF, please [email](#) it to us a few days prior to your first visit.

**Registration Information**

Date:

Name:  Preferred Pronouns:

Address:

City:  State:  Zip Code:

Birth Date:  Gender:

Occupation:

Emergency Contact including Phone Number:

Indicate best number to reach you for last minute cancellations:

Cell phone:   Home phone:   Work phone:

Email:

Which do you prefer for appointment confirmations:

text (you must reply to the opt-in message),  voicemail, or  email?

*(If you do not receive an automated reminder a few days before each appointment, please call/text (415-255-5729) or email (info@do-sf.com) to make sure you are on the calendar. If you are offered an appointment via text or email and you accept it, your appointment is not set until you receive a reply from Carolina confirming it.)*

# HEALTH HISTORY QUESTIONNAIRE

For any answers requiring more space, continue on page 7 or attach your own document or timeline as indicated, and attach all relevant imaging reports/labs with dates.

Today's Date:

Name:

Gender:

DOB:

Referred by:

Date of last physical exam:

## WHAT IS THE MAIN REASON(S) YOU ARE SEEKING TREATMENT?

## PERSONAL HEALTH HISTORY

### List all medical problems (include year of onset)

### Surgeries/Procedures/Major Dental Work (include year), including all injections

### Hospitalizations (other than those associated with surgeries/procedures listed above, include year and diagnosis)

### List your prescribed drugs and over-the-counter medications, supplements, and herbs (include strength and how often you take them)

### Allergies to medications, foods, environment (include the reaction you had)

**List other Providers/Treatments and any adverse reactions you may have had to prior treatments**

**Traumas, Injuries, Accidents, Broken Bones, Head Injuries, indicating any time of loss of consciousness (include year and diagnosis) as well as PTSD, assaults, abuse or other emotional traumas.**

**Your Own Birth History (as much as possible)**

Pregnancy:  Full term  early  late Type of Delivery:  Vaginal  C-Section  Forceps used? Birth Weight:

Number of older siblings:  Number of younger siblings:

Any other Complications?

**Obstetric history (women only)**

Number of pregnancies:  Number of full term births:  Number of premature births:  Number of miscarriages/abortions:

List any issues or complications for each pregnancy/delivery including back pain, difficult labor, induction, epidural, vacuum or forceps, scheduled vs. emergency C-Sections, as well as difficulties for the baby.

<b>Hypermobility Screen</b>	Can you (or could you ever) place your hands flat on the floor without bending your knees?	<input type="checkbox"/> Yes
	Can you (or could you ever) bend your thumb to touch your forearm?	<input type="checkbox"/> Yes
	As a child could you contort your body into strange shapes OR do the splits?	<input type="checkbox"/> Yes
	As a child or teenager did your shoulder or kneecap dislocate on more than one occasion?	<input type="checkbox"/> Yes
	Do you consider yourself double-jointed?	<input type="checkbox"/> Yes
<b>Osteoporosis Risk Factors</b>	Do you have a small/thin frame?	<input type="checkbox"/> Yes
	Are you Caucasian or Asian?	<input type="checkbox"/> Yes
	Have you had broken bones in adulthood without significant trauma?	<input type="checkbox"/> Yes
	Are you postmenopausal?	<input type="checkbox"/> Yes
	Do you experience early or induced menopause?	<input type="checkbox"/> Yes
	Have you been on high doses thyroid medicines?	<input type="checkbox"/> Yes
	Have you taken steroids for longer than 3 months?	<input type="checkbox"/> Yes
	Have you been on chemotherapy/Immunosuppressive medicine?	<input type="checkbox"/> Yes
	Do you have a sedentary lifestyle?	<input type="checkbox"/> Yes
	Are you or have you ever smoked regularly?	<input type="checkbox"/> Yes
	Do you regularly (or have you ever) drink >4 Alcoholic Beverages per Week	<input type="checkbox"/> Yes

<b>Cardiac Risk Factors</b>	Are you male?	<input type="checkbox"/>	Yes
	Are you a male age 55 /female age 65 or older?	<input type="checkbox"/>	Yes
	Any family History of Heart Attack or Stroke in Female relatives under Age 60/Males relatives under Age 55?	<input type="checkbox"/>	Yes
	Do you smoke?	<input type="checkbox"/>	Yes
	Exercise Less Than 3 Times per Week?	<input type="checkbox"/>	Yes
	Eat Less than 4 Servings of Fruit and Vegetables per Day?	<input type="checkbox"/>	Yes
	Do you have Diabetes?	<input type="checkbox"/>	Yes
	Do you have Heart Disease?	<input type="checkbox"/>	Yes
	Have you had a Heart Attack or Stroke?	<input type="checkbox"/>	Yes
	Do you have High Blood Pressure?	<input type="checkbox"/>	Yes
	Do you have high bad cholesterol (LDL)?	<input type="checkbox"/>	Yes
	Do you have low good cholesterol (HDL) and high triglycerides?	<input type="checkbox"/>	Yes
<b>SOCIAL HISTORY</b>			
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Gender of partner: <input type="text"/>			
Type of exercise and frequency: <input type="text"/>			
List any dietary restrictions/preferences: <input type="text"/>			
<input type="checkbox"/> No caffeinated drinks <input type="checkbox"/> Tea <input type="checkbox"/> Coffee <input type="checkbox"/> Cola <input type="checkbox"/> other <input type="text"/>			
# of cups/cans per day? <input type="text"/>			
Do you drink alcohol? <input type="checkbox"/> Yes			
If yes, what kind? <input type="text"/>			
How many drinks per week? <input type="text"/>			
Do you use or have you ever used tobacco? <input type="checkbox"/> Yes			
<input type="checkbox"/> Cigarettes – pks./day <input type="text"/> <input type="checkbox"/> Chew - #/day <input type="text"/> <input type="checkbox"/> Pipe - #/day <input type="text"/> <input type="checkbox"/> Cigars - #/day <input type="text"/>			
# of years <input type="text"/> Or year quit <input type="text"/>			
Do you currently use recreational drugs? <input type="checkbox"/> Yes			
Have you ever given yourself street drugs with a needle? <input type="checkbox"/> Yes			
Are you sexually active? <input type="checkbox"/> Yes			
If yes, are you trying for a pregnancy? <input type="checkbox"/> Yes			
If not trying for a pregnancy list contraceptive used: <input type="text"/>			
Is stress a major issue for you? Major stressors: <input type="text"/> <input type="checkbox"/> Yes			
Do you have trouble sleeping? <input type="checkbox"/> Yes			
If yes, do you have trouble: <input type="checkbox"/> falling asleep <input type="checkbox"/> staying asleep Avg. hours per night? <input type="text"/>			

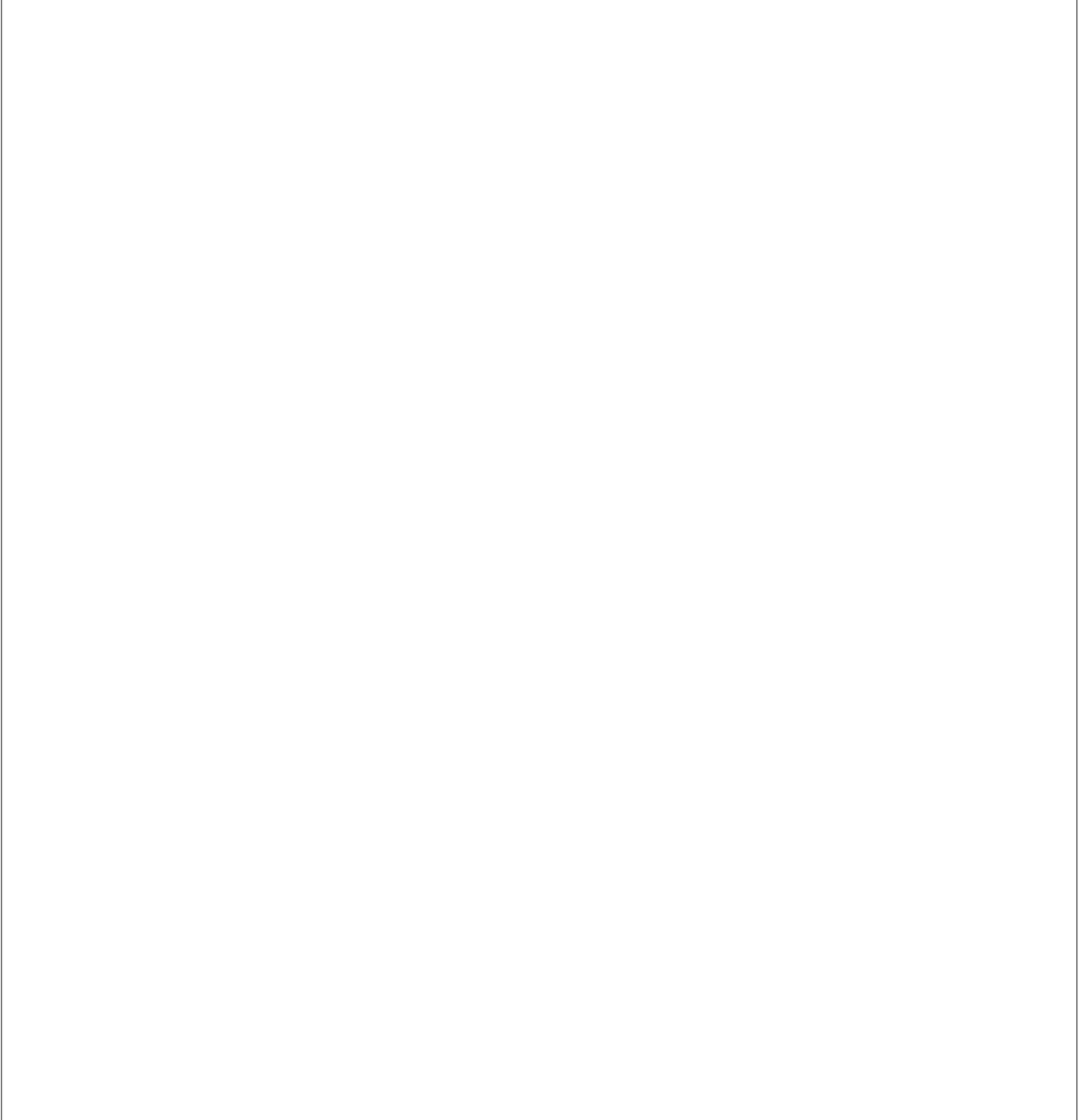
FAMILY HEALTH HISTORY							
	BIRTH YR/GENDER		SIGNIFICANT HEALTH PROBLEMS		BIRTH YR/GENDER		SIGNIFICANT HEALTH PROBLEMS
<b>Mother</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<b>Children</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Father</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Sibling</b>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<b>Grandmother</b> <i>Maternal</i>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<b>Grandfather</b> <i>Maternal</i>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<b>Grandmother</b> <i>Paternal</i>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	<b>Grandfather</b> <i>Paternal</i>	<input type="text"/>	<input type="text"/>	

WOMEN ONLY			
Date of last menstruation:	<input type="text"/>	Age at onset of menstruation:	<input type="text"/>
How many days does your menstruation last?	<input type="text"/>	How many days do your cycles last?	<input type="text"/>
Heavy periods, irregularity, spotting, pain, or discharge?	<input type="text"/>	<input type="checkbox"/>	Yes
Are you currently pregnant or breastfeeding?	<input type="text"/>	<input type="checkbox"/>	Yes
Have you had a D&C, hysterectomy, or Cesarean?	<input type="text"/>	<input type="checkbox"/>	Yes
Any discomfort with intercourse?	<input type="text"/>	<input type="checkbox"/>	Yes
Any urinary tract, bladder, or kidney infections within the last year?	<input type="text"/>	<input type="checkbox"/>	Yes
Any blood in your urine?	<input type="text"/>	<input type="checkbox"/>	Yes
Any problems with control of urination?	<input type="text"/>	<input type="checkbox"/>	Yes
Any hot flashes or sweating at night?	<input type="text"/>	<input type="checkbox"/>	Yes
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="text"/>	<input type="checkbox"/>	Yes
Have you experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="text"/>	<input type="checkbox"/>	Yes
Date of last Pap exam?	<input type="text"/>	Any abnormalities in the past?	<input type="checkbox"/>

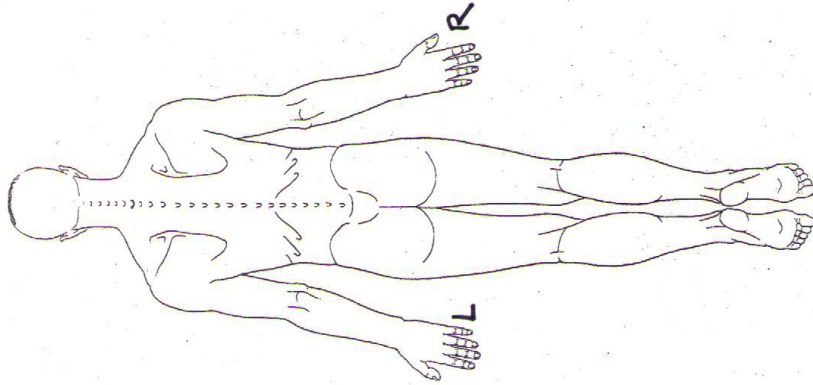
MEN ONLY			
Do you usually get up to urinate during the night?	<input type="checkbox"/>	Yes	
If yes, # of times:	<input type="text"/>		
Do you feel pain or burning with urination?	<input type="checkbox"/>	Yes	
Any blood in your urine?	<input type="checkbox"/>	Yes	
Do you feel burning discharge from penis?	<input type="checkbox"/>	Yes	
Has the force of your urination decreased?	<input type="checkbox"/>	Yes	
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/>	Yes	
Do you have any problems emptying your bladder completely?	<input type="checkbox"/>	Yes	
Any difficulty with erection or ejaculation?	<input type="checkbox"/>	Yes	
Any testicle pain or swelling?	<input type="checkbox"/>	Yes	
Date of last rectal/prostate exam?	<input type="text"/>		



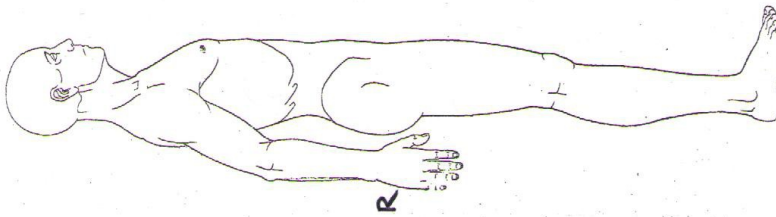
For any answers requiring more space, please fill in below:

A large, empty rectangular box with a thin black border, intended for students to write their answers. It occupies most of the page below the instruction.

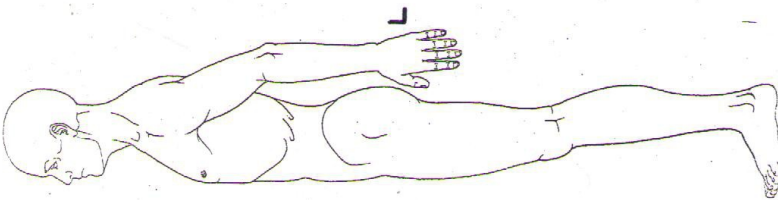
Please mark this page up as indicated or print and markup by hand.



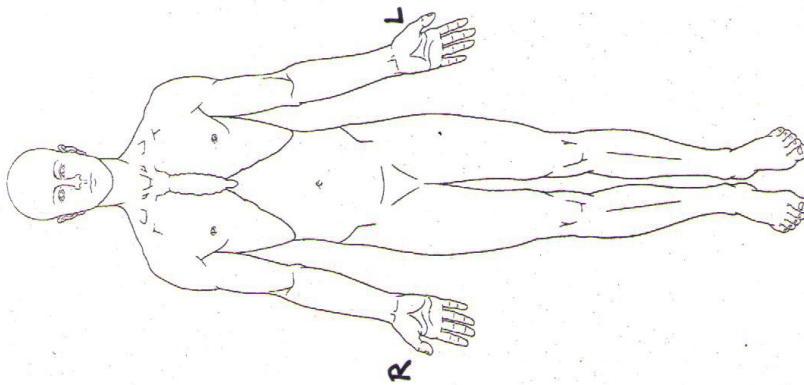
Back



Right Side



Left Side



Front

Please mark areas of pain/concern with an X.

Circle any areas of numbness/tingling.