MEDICAL HISTORY

AWAKENHEALTH MEDICAL CENTER

"AwakenHealth™ through the Art of Medicine"

DR. ARLETTE PHARO, D.O.

Founder of AwakenHealth Medical Center • Specializing in Family Medicine & Integrative Medicine

"Blending" Conventional and Alternative Medicine Providing Patients with the Best of Both Medical Worlds

Doctors of Osteopathy: Physicians Treating People - Not Just Symptoms

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Communication is a valuable key to success in any relationship. Thank You for taking your time to fill out this Medical History Form.
We want to make sure you are receiving the best possible care by understanding your individual and specific needs by evaluating your Medical History. Understanding what you want to receive and expect from your doctor-patient relationship is very important to us. It is also required by the current laws governing licensed physicians in Texas that all New Patients provide an accurate Medical History to the physician they are wanting to establish a patient / physician relationship with. This Medical History Form has been created with the intent to honor all current laws while meeting patient's needs and honoring the physician's requirements for establishing accurate medical records. Please be as specific as possible so we can provide you optimum medical care. Please use the back of pages if needed for complete answers. This may seem like a long form, however, the most important thing to us is your health! Your Health History provides us important information to help you with the best treatment plans, protocols and suggestions for your health care.
Thank You for your time and interest in Awakening Your Health with Dr. Arlette Pharo, D.O.

1). Personal Information:

PLEASE PRINT: **TODAY'S DATE**: ________/_______/ **2015** • **Your Birth Date**:________/_______/_______ **Male** ○ **Female** ○

NAME: (Last)___________________________+____________ (First)________________________________ (Middle)___________________________

ADDRESS: ____+________________________
(Street) (City) (State) (Zip)

PHONE: **Hm**: (_______)________________________ **Cell:** (_______)________________________ **Wk:** (_______)_________________________

FAX: (_______)____________________________ **Location of Fax** (Hm, Wk, Other):____

EMAIL: Personal ____ Wk: ____

Would you like to be on our mailing list? **No**__ / **YES**__, If Yes, How would you like us to contact you: **Email** ○ **Fax** ○ **Standard Mail** ○

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2). Make a Concise List Of Specific Problems / Symptoms You Want To Discuss During Your Appointment Today:

List your symptoms, when they started and if you know what may be contributing to them:

3). Have You Been Diagnosed with an Illness Recently? NO ○ / YES ○ *Please describe briefly if different or additional to above.*

Who gave you this diagnosis as indicated above? NAME:____

Phone (_______)________________________________ Address: ____

City:________________________________ State:________________________________ Approximate Date of Diagnosis: _______/_______/_______

4). Have you been hospitalized for the diagnosis listed in question 2 or 3 above ? NO ○ / YES ○ *If Yes, provide additional information:*

(Use Back of Page if Needed for Answer) Hospital/Clinic: ____City:________________________ State:________
Approximate Date(s)_______/_______/_______

*Please Sign Each of 8 Pages After Reading &Providing Requested Information: X*____*Date:*______/______/ 2015

5). Are You Scheduled For Any Treatments, Surgeries or Hospitalization?

NO ○ / YES ○ Reason: ____

Hospital/Clinic: ________________________City:________________ State:________ Approximate Date(s)_______/_______/_______

6). Are You Currently On Any Perscription Medications, Vitamins or Nutritional and/or Herbal Supplements?

NO ○ / YES ○ **Please list as many as possible, dosage, how long you have been taking them and their purpose. It is important for Dr. Pharo to review your medications, vitamins and/or supplements to make sure there is no interaction between them. (Provide Info Below):**

____

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7). What significant changes have occurred in your life recently than may affect your health, stress level, diet, sleep and energy?
Please list items such as social changes; travel; marriage; divorce; starting a new job; moving your home or business; Illness or death of a loved one; visitors moving in or out of your home; circumstances with spouse, children, friend or anything else that might affect your health.

8). NUTRITION HISTORY: *Please √ Check the Column "or" Make a Brief Comment that Best Applies for the Following:*

DO YOU EAT:	√ NO	√ YES	Occasionally	Describe Details	Special Diet	Other / Notes:
BREAKFAST						
LUNCH						
DINNER						
Snack Frequently						
VEGITARIAN						
MEAT						
FISH						
POULTRY						
*Low Fat Diet				Fat inTake (_______)	Grams per Day	
CAFFEINE				Amt per Day: Amt per Week:		
ALCOHOL				Amt per Day: Amt per Wk:		
TOBACCO				Amt per Day: Amt per Wk:		

****ADDITIONAL COMMENTS REGARDING YOUR PERSONAL NUTRITION:* *(Please use back of page if needed for complete answer).*

*Please Sign Each of 8 Pages After Reading &Providing Requested Information: X*________________________________*Date:*______/______/ 2015

9). FAMILY HISTORY: *(Please use back of page if needed for complete answer).*

FAMILY MEMBER: PRESENT AGE or AGE at DEATH: IF LIVING, Health Condition (Good, Fair, Poor) **IF DECEASED, Cause**

FATHER: ______________________________

MOTHER: ______________________________

BROTHER(s): ______________________________

SISTER(s): ______________________________

CHILDREN: ______________________________

Spouse: ______________________________

Significant Other: ______________________________

Other Relations that could influence on your health and wellbeing: ______________________________

HAS ANY MEMBER OF YOUR FAMILY HAD THESE PROBLEMS? Please √ Check Column or Make Brief Comment That Applies for the Following:

"FAMILY" HEALTH :	√ NO	√ YES	What Famliy Member? Notes:
Anemia			
Arthritis			
Asthma			
Bleeding Tendency			
Breast Cancer			
Cancer			
Chronic Fatigue			
Chronic Lung Disease			
Colon Disease			
Diabetes			
Gout			
Heart Disease			

"FAMILY" HEALTH :	√ NO	√ YES	What Famliy Member? Notes:
High Blood Pressure			
HIV / AIDS			
Kidney Disease			
Leukemia			
Mental Illness			
Migraines			
Obesity			
Seizures			
Severe Allergies			
Thyroid Disease			
Tuberculosis			
*Other (Specify)			

****ADDITIONAL COMMENTS REGARDING YOUR FAMILY HEALTH PROBLEMS:* *(Please use back of page if needed for complete answer).*

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10). "YOUR" PAST MEDICAL HISTORY: HAVE YOU EVER HAD ANY OF THE FOLLOWING:

"YOUR" HEALTH:	NO	YES	Other / Notes & Dates:
Allergies			
Anemia			
Arthritis			
Asthma			
Back Problems			
Bladder Infection			
Bleeding Tendency			
Blood Transfusions			
Breast Cancer			
Bronchitis			
Cancer			
Chronic Fatigue			
Chronic Infections			
Chronic Lung Disease			
Chronic Sinusitis			
Colon Disease			
Diabetes			
Diphtheria			
Endometriosis			
Fibrocystic Breasts			
Gout			
Heart Disease			

"YOUR" HEALTH:	NO	YES	Other / Notes & Dates:
*Hepatitis (Yellow Jaundice)			*Circle Type: A B C
High Blood Pressure			
**HIV			**Circle if Opportunistic
Hives			
Hypoglycemia			
Infectious MONO			
Kidney Disease			
Measles			
Meningitis			
Mental Illness			
Migraines			
Mumps			
Opportunistic Infection			
Pleurisy			
Pneumonia			
Polio			
Rheumatic Fever			
Scarlet Fever			
TB "or" (Exposure To It)			
Tuberculosis			
Ulcer			
*Other (Specify)			

11). Have You EVER had a Sexually Transmitted Infection? *Circle Answer:* **NO / YES "or" Venereal Disease: NO / YES**

If YES to having Infection or Disease, Please Specify: {Use back of page if needed for answer}

*Please Sign Each of 8 Pages After Reading &Providing Requested Information: X*______________________*Date:*_____/_____/ 2015

12). OPERATIONS, INJURIES & PROCEDURES: HAVE YOU EVER HAD ANY OF THE FOLLOWING

(List, Describe and Date)

OPERATIONS:	√ NO	√ YES	Other / Notes:	Dates:
Appendix				
Breast				
Gall Bladder				
Heart				
Hemorrhoids				
Hernia				
Laminectomy				
Laparoscopy				
Prostate				
Stomach				
Thyroid				
Tonsils				
Uterus *and/or* Ovaries				
Plastic Surgery			Why:	
" "			Where:	
" "			Elective, Yes__ / No__	
*Other (Specify)				

INJURIES:	√ NO	√ YES	Other / Notes:	Dates:
Abdomen				
Arms				
Back				
Broken Bones				
Chest				
Feet				
Hands				
Head				
Legs				
*Other (Specify)				

PROCEDURES:	√ NO	√ YES	Other / Notes:	Dates:
Colonoscopy				
Hormone Therapy				
MRI				
XRAY				
LifeScan				
*Other (Specify)				

***ADDITIONAL COMMENTS REGARDING YOUR OPERATIONS & INJURIES: *(Please use back of page if needed for complete answer).*

13). ALLERGIES & IMMUNIZATIONS, HAVE YOU EVER HAD ANY OF THE FOLLOWING:

ALLERGIES:	√ NO	√ YES	Other / Notes:
ALLERGY TESTING			
ALLERGIC To:			
Cosmetics			
Foods (Specify)			
Environment (Specify)			
ALLERGIC to DRUGS			
Penicillin			
Sulfur			
Tetanus			
*Other (Specify)			

IMMUNIZATION:	√ NO	√ YES	Other / Notes:	Dates:
Hepatitis				
Polio				
Smallpox				
Tetanus				
Flu				
*Other (Specify)				

***ADDITIONAL COMMENTS REGARDING YOUR ALLERGIES & IMMUNIZATIONS: *(Please use back of page if needed for complete answer).*

14). REVIEW of SYSTEMS, HAVE YOU EVER HAD ANY OF THE FOLLOWING: (CHECK APPROPRIATE BOX for EACH ITEM BELOW)

(Please use back of page if needed for complete answer).

Review of Systems:	√ NO	√ Current	√ Previous	Dates & Notes:
GENERAL:				
Tire Easily or Weakness				
Sudden Weight Change				
Weight Chg Up or Down?				How Much Wt?
Night Sweats				
Persistent Fever				
Sensitivity to Heat				
Sensitivity to Cold				
*Other (Specify)				

Review of Systems:	√ NO	√ Current	√ Previous	Dates & Notes:
EYES:				
Difficulty Seeing				
Eye Pain				
Double Vision				
Wear Glasses/Contacts				
Cataracts				
*Other (Specify)				

*Please Sign Each of 8 Pages After Reading &Providing Requested Information: X*______________________________*Date:*_____/_____/ 2015

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(14. Continued): REVIEW of SYSTEMS, HAVE YOU EVER HAD ANY OF THE FOLLOWING:

(CHECK APPROPRIATE BOX for EACH ITEM BELOW) *(Please use back of page if needed for complete answer).*

Review of Systems:	√ NO	√ Current	√ Previous	Dates & Notes:
NERVOUS SYSTEM:				
Headaches				
Dizziness				
Fainting				
Seizures				
Anxiety				
Depression				
Memory Loss				
Difficulty Sleeping				
Numbness & Tingling				
Loss of Strength				
Paralysis				
Changes Sense of Touch				
*Other (Specify)				
RESPIRATORY :				
Persistent Cough				
Chronic Sputum (phlegm)				
Cough Up Blood				
Shortness of Breath				
Wheezing				
Pain Breathing				
Difficult Breath LyingDown				
Bluish Fingers or Lips				
*Other (Specify)				
CARDIO-VASCULAR:				
Chest Pain or Discomfort				
Heart Palpitations				
High Blood Pressure				
Stroke				
Varicose Veins				
High Cholesterol				
Heart Murmur				
*Other (Specify)				
ENDOCRINE:				
Diabetes				
Adrenal Problems				
Cortisone TX Longterm				
Thyroid Problems				
Pituitary Problems				
Polycystic Ovary Disease				
Hormonal Imbalance				
PMS				
*Other (Specify)				
BREAST:				
Breast Lump				
Nipple Discharge				
Fibrocystic Changes				
Breast Implants				
Breast Cancer				
*Other (Specify)				

Review of Systems:	√ NO	√ Current	√ Previous	Dates & Notes:
EARS:				
Loss of Hearing				
Ringing in your Ears				
Discharge from Ears				
Itching Ears				
*Other (Specify)				
NOSE:				
Loss of Smell				
Sinus Drainage				
Nose Bleeds				
Deviated Septum				
*Other (Specify)				
THROAT:				
Soreness				
Difficulty Swallowing				
Post Nasal Drainage				
Chronic Hoarseness				
*Other (Specify)				
MOUTH:				
Bad Breath				
Dental Problems				
Silver Dental Fillings				
Sore Gums				
Soreness of Tongue				
Canker Sores				
Cold Sores				
*Other (Specify)				
SKIN:				
Acne				
Eczema				
Psoriasis				
Rashes				
Changes in Nails				
Hair Loss				
*Other (Specify)				
MUSCLES & JOINTS:				
Muscle Pain				
Muscle Weakness				
Muscle Cramps				
Pain in Joints				
Swollen Joints				
Deformity in Joints				
Stiffness				
*Other (Specify)				

*Please Sign Each of 8 Pages After Reading &Providing Requested Information: X*____*Date:*_____/_____/ 2015

(14. Continued): REVIEW of SYSTEMS, HAVE YOU EVER HAD ANY OF THE FOLLOWING:

(CHECK APPROPRIATE BOX for EACH ITEM BELOW) *(Please use back of page if needed for complete answer).*

Review of Systems:	√ NO	√ Current	√ Previous	Dates & Notes:
GASTROINTESTINAL:				
Change in Appetite				
Difficulty Swallowing				
Heart Burn (Indigestion)				
Belching				
Flatulence (excess gas)				
Abdominal Bloating				
Nausea				
Vomiting				
Vomiting Blood				
Constipation				
Diarrhea				
Hemorrhoids				
Rectal Bleeding				
Tarry Stools				
Need for Laxatives				
Gallstones				
Abdominal Pain				
*OTHER (SPECIFY):				

Review of Systems:	√ NO	√ Current	√ Previous	Dates & Notes:
EYES:				
Difficulty Seeing				
Eye Pain				
Double Vision				
Wear Glasses/Contacts				
Cataracts				
*OTHER (SPECIFY):				
GENITOURINARY:				
Urination (Info):				
Urination Pain/Burning				
Increase Frequency (day)				
More Frequency (night)				
Urgency to Urinate				
Incontinence: (Unable to Hold Urine)				
*OTHER (SPECIFY):				

***ADDITIONAL COMMENTS REGARDING REVIEW OF YOUR SYSTEMS: *(Please use back of page if needed for complete answer).*

15). What Healing Modalities Have You Tried Before? What Alternative Healing Modalities Are You Interested In Knowing About?

Please √ check the column OR make a brief comment that best applies for the following:

HEALING MODALITIES:	√ CURRENT	√ OFTEN	√ SELDOM	√ Not Experienced	√ Interested	Other / Notes:
Acupuncture						
Aromatherapy						
Chelation Therapies						
Chiropractic						
Colonics						
Cranial-Sacral Therapy						
Massage						
Neural Therapy						
OMT, Osteopathic Manipulation						
Psychotherapy						
Reiki						
Yoga						
Other: (Specify)						
Other: (Specify)						
Other: (Specify)						
Other: (Specify)						

***ADDITIONAL COMMENTS REGARDING YOUR MEDICAL HISTORY, ALTERNATIVE HEALING MODALITIES & HEALTHCARE NEEDS:
(Please use back of page if needed for complete answer).

(Continued): MEDICAL HISTORY: *(Please use back of page if needed for complete answer).*

16). Have you had any Tooth Aches, Dental Problems or Dental Work Done Lately?

NO O / YES O If Yes, Specify: Dates:______/_______/______Dentist Name:___________________________________ Phone:_________________

Specify Type of Dental Problem or Work Done:____

17). Are you interested in a Custom Wellness Plan to help "Awaken Your Health" in your life?

Areas of interest for your awakened health: Nutrition Analysis; Vitamins & Supplements; Diet Plan for Weight Loss or Weight Gain; Healthy Heart; Healthy Aging; Improved Immune System; I.V. Infusion Therapy; Improved Sleep; Improved Energy; Diagnostics for Certain Condition or Wellness Profile; Other: *(List or Describe Details)*

____

18). OB / GYN – WOMEN ONLY: Date of Last PAP Test:_______/_______/_______ **Details Regarding Last PAP Test:**

Normal O / **Abnormal** O *Details:* ____ **Type of PAP Test**: (*Circle Type if Known*):

Conventional PAP Smear *(Collection and "smearing" cervical cells on slide, collected cells sent to lab in a vial for testing)*

Liquid-Based Pap Tests *(ThinPrep® & SurePath®) (Cervical cells placed in jar of liquid fixative for rinsing & transport to lab)*

PAP Lab-Testing Done For: (*Circle if Known*): Detection of Cervical Cancer, Pre-Cancerous Lesions, Atypical Cells, HPV,DNA Testing, Gonorrhoeae, Chalamydia, Genital Warts (Condylomata), Other: ___________________________________

Started Menstruating at Age:____ Date of Last Cycle:_______/______/_______ Frequency of Periods:____________________________

Average # of Days of Menstrual Cycles___Days **Duration of Normal Cycle**:__Days **Flow:** Light O / Normal O / Heavy O

Additional Info Menstrual Cycle: ____

Pain with Cycle: NO O / YES O If Yes, Specify:____

Do You Clot with Your Menstrual Cycles: NO O / YES O If Yes, Specify:____

Endometriosis: NO O / YES O If Yes, Specify:____

Number of Miscarriages:_____ **Number of Births**:_____ Vaginal O C-Section O **Did You Breast Feed?** NO O YES O

Specify Any Important Birthing Details:____

____

Date of Last Mammogram:_____/_____/_____ Results of Mammogram: ____

Have You Experienced Thermography: NO O / YES O If Yes, Specify Dates, Type, Where and Results of Thermography:

____

Monthly Breast Self-Exams? NO O / YES O Occasionally O Specify:____

Are You Sexually Active? NO O / YES O Occasionally O Specify:____

Experience Pain w/ Intercourse? NO O / YES O Occasionally O Specify:____

Method of Contraception: ____ Are You Satisfied with this method? NO O / YES O

Experience Night Sweats? NO O / YES O Occasionally O Specify:____

Experience Hot Flashes? NO O / YES O Occasionally O Specify:____

Experience Hot/Cold Intolerance? NO O / YES O Occasionally O Specify:____

Please Sign Each of 8 Pages After Reading &Providing Requested Information: X____*Date:*______/______/ 2015

19). OB / GYN – HEALTH HISTORY WOMEN ONLY:

Note: Some questions listed in chart below may have been previously asked on this Medical History Form. Please answer ALL questions on this page as part of your OB/GYN Medical History in order to provide Dr. Pharo the most complete review in this category for WOMEN'S HEALTH.

(WOMEN'S HEALTH CHECK APPROPRIATE BOX for EACH ITEM BELOW)

OB/GYN: Women Only	√ NO	√ Current	√ Previous	Dates & Notes:
Fever				
Weight Gain / Loss				
Change in Appetite				
Fatigue				
Mood Swings				
Depression				
Sleep Disturbances				
Flatulence (excess gas)				
Abdominal Bloating				
Abdominal Pain				
Nausea				
Vomiting				
Vomiting Blood				
Constipation				
Need for Laxatives				
Diarrhea				
Hemorrhoids				
Rectal Bleeding				
Tarry Stools				
Bloody Stools				
Gallstones				
Ear Ache				
Ringing in Ear				
Vision Changes				
Dry Eyes				
Red, Itchy Eyes				
Eye Disease/Disorder				
Sinus Pain/Headache				
Headaches				

OB/GYN: Women Only	√ NO	√ Current	√ Previous	Dates & Notes:
Chest Pain				
Rapid Heart Beat				
Persistent Cough				
Wheezing				
Shortness of Breath				
Hard to Breath (Lying Dwn)				
Mouth Sores				
Persistent Sore Throat				
Swollen Lymph Nodes				
Skin Rash				
Hives, Blisters				
Dizziness				
Numbness				
Seizures				
Incontinence: (Unable to Hold Urine)				
Urination Pain/Burning				
Increase Frequency (day)				
More Frequency (night)				
Urgency to Urinate				
Joint or Muscle Pain				
Muscle Weakness				
Swollen Hands or Feet				
Easy Bruising				
Easy Bleeding				
Painful Breasts				
Breast Lumps				
Nipple Discharge				
*OTHER (SPECIFY):				

20). OB / GYN – MENOPAUSAL WOMEN ONLY:

Do You Use Hormones? No ○ / Yes ○ Occasionally ○ If So, What Type? Specify:______________________________

Any Vaginal Bleeding? No ○ / Yes ○ Occasionally ○ If So, Specify:______________________________

When Did Your Menstrual Periods Stop? Specify:______________________________

Have You Had A Colonoscopy? No ○ / Yes ○ If Yes, Dates & Specifics:______________________________

Have You Had A Bone Density Test? No ○ / Yes ○ If Yes, Dates & Specifics:______________________________

What Other Tests, Exams or Conditions Relate To Your Menopausal Health? Specify:______________________________

Use The Space Below If Needed For Additional Information Regarding Your Health & Medical History: