James E Gaydos DO
CONFIDENTIAL HISTORY FORM

Name ____ Date _____________________

What is your Job? ___________________ Single / Married/ Divorced/ Widowed (Circle One)

PLEASE MARK ALL RECENT OR CONTINUOUS CONDITIONS THAT APPLY WITH A CHECK-MARK (√)

( ) FEVER/ CHILLS
( ) WEIGHT LOSS
( ) WEIGHT GAIN
( ) BRAIN FOG
( ) DECLINE IN HEALTH
( ) POST TRAUMATIC HISTORY
( ) ADDICTION HISTORY
( ) JAIL HISTORY
( ) EARLY LIFE ADVERSITY

( ) HEAD INJURY
( ) COMA HISTORY
( ) DENTAL OR JAW PAIN
( ) HEAD SURGERY HISTORY

( ) VISION LOSS
( ) VISION CHANGE
( ) CORRECTIVE LENS USE
( ) EYE DISEASE
( ) EYE PAIN
( ) EYE SURGERY HISTORY

( ) POST-NASAL DRAINAGE
( ) SINUS INFECTION HISTORY
( ) NASAL OBSTRUCTION
( ) MOUTH BREATHING
( ) LOSS OF SMELL
( ) SINUS/NOSE SURGERY HISTORY

( ) DENTAL PAIN
( ) DENTAL DISEASE
( ) TONGUE PAIN
( ) ORAL SORES/CANCER
( ) LOSS OF TASTE
( ) ORAL SURGERY HISTORY

( ) EAR PAIN
( ) EAR DISCHARGE
( ) EAR INFECTION HISTORY
( ) HEARING CHANGE
( ) RINGING IN EARS
( ) DIZZINESS
( ) HEARING AIDE
( ) EAR SURGERY

( ) FREQ SORE THROATS
( ) VOICE CHANGE
( ) THROAT PAIN
( ) THROAT LUMPS
( ) PAST THROAT SURGERY

( ) COUGH
( ) WHEEZE
( ) ASTHMA
( ) BRONCHITIS
( ) PNEUMONIA HX
( ) + TB HISTORY
( ) SHORT OF BREATH

( ) HIGH BP
( ) HEART DISEASE
( ) CHOLESTEROL
( ) PASSING OUT
( ) BLOOD CLOTS
( ) SHORT OF BREATH
( ) PALPITATIONS
( ) CHEST PAIN
( ) HEART SURGERY

( ) SWALLOW PROBLEM
( ) HEARTBURN
( ) FOOD INTOLERANCE
( ) NAUSEA/VOMITING
( ) LIVER DISEASE
( ) GALL BLADDER DISEASE
( ) EXCESSIVE GAS & BLOATING
( ) ABDOMEN PAIN
( ) ULCER DISEASE
( ) BLOOD IN VOMIT
( ) BLOOD IN STOOL
( ) CHANGE IN STOOL TYPE
( ) CHANGE IN STOOL FREQUENT
( ) CHANGE IN STOOL COLOR
( ) STOOL LOSS WITH COUGH / SNEEZE
( ) BOWEL DISEASE
( ) BOWEL SURGERY

( ) NECK PAIN
( ) THORACIC SPINE PAIN
( ) LUMBAR SPINE PAIN
( ) PELVIC PAIN
( ) LIMB PAIN
( ) LIMB WEAKNESS
( ) JOINT RED / WARM / SWELL
( ) LOSS OF JOINT MOTION
( ) BONE FRACTURE HISTORY
( ) AUTOIMIMMUNE DISEASE
( ) GOUT
( ) BONE THINNING
( ) FALL HISTORY
( ) BONE/ DISK / TENDON SURGERY

( ) ANXIETY
( ) DEPRESSION
( ) MENTAL DISEASE
( ) MEMORY CHANGE
( ) POOR SLEEP
( ) DISTURB SLEEP
( ) PTSD
( ) EXCESS STRESS
( ) EATING DISORDER
( ) SEASONAL AFFECTIVE DS
( ) MULTIPLE CHEMICAL DS
( ) CHRONIC FATIGUE
( ) ADDICTION HISTORY
( ) HOSPITALIZATION HISTORY

( ) BREAST PAIN
( ) BREAST DISEASE HX
( ) BREAST MASS
( ) BREAST DISCHARGE
( ) SELF EXAM BREASTS
( ) BREAST SURGERY HX

( ) RASHES
( ) CHRONIC ITCH
( ) ECZEMA
( ) SKIN DISEASE
( ) NAIL CHANGES
( ) HAIR CHANGES
( ) MOLE CHANGES
( ) SKIN SURGERY

( ) TENSION HEADACHE
( ) MIGRAINE HEADACHE
( ) BRAIN INJURY
( ) COMA HISTORY
( ) SEIZURE HISTORY
( ) BRAIN DISEASE HISTORY
( ) RADIATING PAINS
( ) NUMBNESS
( ) TINGLING
( ) RESTLESS LEGS
( ) NERVE SURGERY

( ) THYROID DISEASE
( ) DIABETES
( ) ADRENAL DISEASE
( ) IRREGULAR MENSES
( ) MENOPAUSAL
( ) HOT FLASHES
( ) COLD INTOLERANCE
( ) NIGHT SWEAT
( ) WEIGHT GAIN
( ) WEIGHT LOSS
( ) ENDOCRINE DISEASE
( ) ENDOCRINE SURGERY

( ) ANEMIA HISTORY
( ) BLOOD DISEASE
( ) EASY BLEEDING/BRUISING
( ) BLOOD CLOT HISTORY

( ) SWOLLEN LYMPH NODES
( ) CANCER HISTORY

( ) ITCHY EYES/ NOSE
( ) RUNNY EYES / NOSE
( ) SEASONAL ALLERGY
( ) FOOD ALLERGY
( ) INSECT ALLERGY
( ) ANAPHYLAXIS HISTORY
( ) CHRONIC YEAST
( ) MOLD ALLERGY
( ) CHRONIC INFECTIONS
( ) HERPES TYPE 1 OR 2
( ) SHINGLES HISTORY
( ) LYME DISEASE HISTORY
( ) CANCER HISTORY

( ) WAKE TO URINATE
( ) PAIN WITH URINATING
( ) URINATE TOO MUCH
( ) INFECTION HISTORY
( ) STONE HISTORY
( ) KIDNEY DISEASE
( ) BLADDER DISEASE
( ) URINE LOSS WITH COUGH/ SNEEZE

( ) PENILE DISEASE
( ) PROSTATE DISEASE
( ) DIFFICULT ERECTIONS
( ) PENILE/ PROSTATE PAIN
( ) DISCHARGE/ BLOOD
( ) HERNIA HISTORY
( ) SCROTAL MASS OR PAIN
( ) GENITAL CANCER
( ) GENITAL / PROSTATE SURGERY

( ) VAGINAL PAIN / DRY
( ) VAGINAL DISCHARGE / ODOR
( ) VAGINAL / UTERINE DISEASE
( ) SEXUALLY ACTIVE
( ) PAINFUL SEX
( ) PREGNANT NOW
( ) MISCARRIAGE / ABORTION
( ) CHANGE IN MENSES
( ) MENOPAUSAL
( ) POST-MENOPAUSAL BLEEDING
( ) GENITAL CANCER
( ) HERNIA

( ) THIS A CAR OR WORK ACCIDENT

FAMILY HISTORY: CHECK (√) OR EXPLAIN THE "TYPE OF DISEASE" FOR EACH

	FATHER	MOTHER	SIBLING	CHILD
AGE ALIVE/DEAD				
TOBACCO				
ALCOHOLISM				
DRUG ABUSE				
JAIL/VIOLENT				
LUNG DISEASE TYPE				
HEART DISEASE				
BLOOD PRESSURE				
DIGESTIVE TYPE				
DIABETES				
THYROID DS				
NEURO DS TYPE				
MENTAL DS TYPE				
ARTHRITIS TYPE				
CANCER TYPE				
CHRONIC PAIN				
KIDNEY DS TYPE				
OVERWEIGHT				
CAUSE OF DEATH				

SOCIAL HISTORY:

HAVE YOU EVER USED TOBACCO HABITAULLY?	( ) YES	( ) NO
WHEN DID YOU STOP? ___________________		
DO YOU USE TOBACCO NOW?	( ) YES	( ) NO
DO YOU USE MARIJUANA?	( ) YES	( ) NO
DO YOU USE COFFEE OR TEA (CIRCLE)	( ) YES	( ) NO
DO YOU USE CHOCOLATE?	( ) YES	( ) NO
DO YOU USE COLA OR ENERGY DRINKS (CIRCLE)	( ) YES	( ) NO
DO YOU USE ASPARTAME?	( ) YES	( ) NO
DO/DID YOU USE ANY STREET DRUGS?	( ) YES	( ) NO
DO YOU HAVE ANY ADDICTION TO FOOD/ DRUGS?	( ) YES	( ) NO
DO YOU USE ALCOHOL?	( ) YES	( ) NO

WHAT TYPES? (CIRCLE) BEER WINE HARD LIQUOR

HOW MUCH DO YOU USE ON A DAILY BASIS?

LIST YOUR MEDICATIONS (STRENGTH & DOSAGE) AND REMEDIES:

LIST YOUR ALLERGIES:

LIST ALL ILLNESSES, HOSPITAL STAYS / SURGERIES / FRACTURES:

WHAT HAPPENED?	WHEN WAS THIS?	WHERE WAS THIS?	COMMENTS?