Green Oaks Medical Center, PC
Dr. Christine Green

2500 Hospital Drive, Bldg 2
Mountain View, CA 94040
650-433-8925/Fax: 650-523-4682

2136 Sutter St.
San Francisco, CA 94115
415-415-968-4384/ Fax: 415-992-5917

NAME: _____DATE OF BIRTH: _____

TODAY'S DATE:_____

ARE YOU ALLERGIC TO MEDICATIONS?: _____YES _____NO

IF YES LIST MEDICATIONS AND REACTION_____

LIST ANY SURGERIES& DATES:_____

_____

LIST ANY NON SURGICAL HOSPITALIZATIONS:_____

LIST ANY MAJOR ACCIDENTS, FALLS, OR BROKEN BONES AND DATES:

CIRCLE ALL THAT YOU HAVE BEEN DIAGNOSED WITH OR WRITE OTHERS IN SPACES

Migraine headache cancer arthritis mono Hepatitis A/ B/ C

Pneumonia irritable bowel heart attack asthma osteoporosis

Vaginal infections jock itch HPV Herpes athletes food Hay Fever

High cholesterol epilepsy diverticulitis ulcerative colitis psoriasis

Parkinson's disease interstitial cystitis LYME disease lupus alcoholism

Endometriosis stroke diabetes hypertension MS

Gallbladder problems kidney disease kidney stones bladder infection glaucoma

Post partum depression PMS hemorrhoids thyroid disease thyroiditis

Bulimia anorexia eating disorder irritable bowel colitis

Other_____

BRIEFLY WRITE YOUR REASON FOR CONSULTING CARE PRODIVERS AT GREEN OAKS MEDICAL:

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FAMILY HEALTH

Please list age, cause and age of death (if deceased), and any major health problems of individuals.

	MATERNAL	PATERNAL
GRANDFATHER		
GRANDMOTHER		
AUNTS		
UNCLES		
PARENTS		
SIBLINGS		
CHILDREN		

PLEASE NOTE CANCER, HEART DISEASE AND TYPE IF PRESENT ABOVE, OSTEOPOROSIS IF PRESENT, ANY AUTOIMMUNE DISEASE, ANY HORMONE PROBLEMS, DIABETES EARLY/ LATE ONSET.

WHAT IS YOUR OCCUPATION?_____

HOW LONG AT THIS OCCUPATION?_____ DO YOU LIKE YOUR WORK? _____
DO YOU HAVE A CLOSED AIR SYSTEM AT WORK? _____

DESCRIBE ANY PART OF YOUR JOB THAT MAY BE HAZARDOUS TO YOUR HEALTH
_____

WHO LIVES IN YOUR CURRENT HOME?
_____

HOW OLD IS THE CURRENT HOME?_____WHERE DID YOU GROW UP?_____

LIST ANY COUNTRIES VISITED, DATES AND CIRCLE THOSE IN WHICH YOU WERE SICK:_____

WHERE DO YOU FIND SUPPORT? MARK THE FOLLOWING BETWEEN 0=NONE AND 3=EXCELLENT

	0	1	2	3
FAMILY				
PARTNER				
CHILDREN				
FRIENDS				
RELIGIOUS GROUP				
HOBBY GROUP				

HABIT TABLE

PLEASE FILL OUT

	PER DAY	PER WEEK
CUPS OF COFFEE		
CAFFEINATED SODA		
OUNCES OF CHOCOLATE		
CUPS OF BLACK TEA		
ALCOHOL		
CIGARETTES		
EXERCISE		
HOURS OF WORK		
HOURS OF PLAY		
OTHER		

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LAST COLONOSCOPY DATE: _____LAST PSA TEST DATE: _____
In terms of hormones I am experiencing (check all that apply):

____ Irritability	**____ Sexual changes**	**____ Swollen glands**
____ Depression	**____ Pain with intercourse**	**____ Acne**
____ Fatigue	**____ Vaginal odor**	**____ Craving food**
____ Poor Sleep	**____ Swollen glands**	**____ Allergies**
____ Feeling Hot	**____ Dry skin**	**____ Dizziness**
____ Night Sweats	**____ Wrinkles**	**____ Pregnancy**
____ Feeling Cold	**____ Forgetfulness**	**____ Change in interest in sex**
____ Cold hands and feet	**____ Fertility problems**	**____ Problems with orgasm**
____ Stiffness	**____Weight gain**	**____ Mood change**
____ Joint pain	**____ Weight loss**	**____ Migraine headaches**
____ Headache	**____ Loss of muscle**	**____ Rashes**
____ Indigestion	**____ Loss of flexibility**	**____ Asthma**
____ Feeling bloated	**____ Erectile dysfunction**	**____ Bulimia**
____ Eating disorders	**____ Weak urine stream**	**____ Anorexia**
____ Loss of urine when I cough or sneeze	**____ Hesitation in urine stream**	**____ Sleep problems**
ROS		

<u>WOMEN ONLY</u>
Menstrual History
Last menstrual period date:_____Last pap smear: _____Last mammogram: _____

Last bone density screen: _____My period began at age: _____

I have been pregnant: _____Times delivered_____ Times miscarried _____
Times terminated _____ Healthy Pregnancy _____Toxemia _____

Menstrual Cycles now are: a. regular _____b. irregular _____c. gone _____ d. unsure _____

I have used birth control for _____ years. My current method of birth control is _____

I have had cancer of: a. breast _____ b. uterine _____ c. ovarian _____

I have had a Tick Bite: Date_____location on body_____ county _____ state___

I have had frequent exposure to Lyme-endemic areas, i.e. brushy or woodsy areas _____

I have frequently had many bites from insects _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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PLEASE CHECK ALL THAT APPLY

I am generally healthy		**I have less energy in the last year**	
My weight has changed significantly in the past 5 yrs		**I binge eat**	
I am troubled by temperature always too cold or too hot		**I am having trouble with abdominal bloating**	
I have dandruff that I have trouble getting rid of		**I am losing hair/my hair is falling out**	
My skin is dry		**I have acne**	
My skin is too oily		**I am more thirsty then I used to be**	
I frequently have nasal congestion or a runny nose		**I am urinating more than I used to**	
I frequently have sinus problems		**My ankles swell occasionally**	
I am bothered by headaches These are new headaches in the past ____years/mos Where in the head? _____ What helps them? _____ Describe the pain? _____ How frequently do they occur?		**My bowel movements are different now than before: Explain**	
I have recurrent swimmers ear		**I have bowel movements daily**	
I often take antibiotics for sinuses		**I have normal formed stool**	
I have athlete foot, jock itch or vaginal yeast infections		**I tend towards constipation**	
I have had thrush		**I have black stool**	
I have toe or fingernail fungus		**I have seen blood in my stool**	
I have ear aches often		**I know I have hemorrhoids**	
I have visual changes		**I am told I snore and this has changed**	
I have chest pain that is new		**I feel tired even after sleeping**	
I have back and/or neck pain		**I cannot easily fall asleep**	
I have swollen joints		**I have trouble staying asleep**	
I have ringing in my ears for the past ____ years		**I am having trouble with my memory**	
I am experiencing sexual problems: Describe		**I often crave the following food(s):**	
I cannot recall names of things		**I have dizziness**	
I burp more often then I used to		**I have fainted recently and do not know why**	
I have muscle cramps		**I sometimes have vertigo**	
I have restless legs		**I have joint pain**	
I have occasional burning or discomfort with urination		**I am stiff in the morning and it takes _____ minutes to feel normal**	
I have been given steroids _____ times for _____ length		**I have shooting pains in _____ for the past _____ years**	
I have used birth control pills for a total of _____ years		**My birth control method is _____**	
I have allergies to _____ Seasonal _____ all year_____		**I have been experiencing numbness, tingling, or funny feelings in _____ for _____ years**	
Other			