

Green Oaks Medical Center, PC
Dr. Christine Green
3200 Middlefield Rd., Suite B
Palo Alto, CA 94306
650-433-8925/Fax: 650-523-4682

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 PROVIDERS 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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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 than 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 than 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 _____ Other	I have been experiencing numbness, tingling, or funny feelings in _____ for _____ years	