Global Medicine
Monique Martin, D.O., Integrative Internist

# Patient History

Name:_____ Age:_____ Referred by:_____

Dr. Martin is a Holistic and Integrative Internal Medicine specialist who addresses the whole person – including body, mind, and spirit. Although this questionnaire is personal, it is confidential, therefore, please answer as honestly and openly as you can.

Have you ever been hospitalized? **Yes** or **No**
If **yes**, please list **reason**(s) and **date**(s):

1._____

2._____

3._____

4._____

5._____

Do you have any chronic illnesses? **Yes** or **No**

Have you had any serious accidents, broken bones, concussions, etc.? **Yes** or **No**

If **yes**, please list type and date:

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Have you had any surgeries (e.g. **tonsils**, **dental/wisdom teeth**, **appendix**, **vasectomy**, **tubal ligation**, **gallbladder**, **cosmetic**, **sinus**, **eye-Lasik/PRK**, **foot**, **joint-hip**, **knee**, **ankle**, **shoulder**, **bone fixations**, **breast**, **C-sections**, **hysterectomy**, **prostate**, **laparoscopic**, **abdominal**, **gallbladder**, **implants**, **sutures**, **biopsies**)? **Yes** or **No**

If **yes**, please list type and date:

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____


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## Family History

☐ Unknown ☐ Adopted

Biological Mother: ☐ Alive ☐ Deceased How old is / was she:_____ years.

Does / did she have any illnesses (please include alcohol, drugs, tobacco)? **Yes** or **No**

If **yes**, please list:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Biological Father: ☐ Alive ☐ Deceased How old is / was he:_____ years.

Does / did he have any illnesses (please include alcohol, drugs, tobacco)? **Yes** or **No**

If **yes**, please list:

7. _____ 10. _____

8. _____ 11. _____

9. _____ 12. _____

Are / were your parents separated or divorced? **Yes** or **No**

If **yes**, how old were you at the time? _____ years.

Whom did you live with? _____

Does / did anyone in the immediate family (children, siblings, parents, aunts, uncles, grandparents) have (please circle): **Cancer** (**prostate**, **breast**, **colon**), **Aids**, **Alcoholism**, **Depression**, **Diabetes**, **Drug abuse**, **Heart disease**, **High blood pressure**, **Migraines**, **Stroke**, **TB**, Other _____

_____

Do you have any full siblings? **Yes** or **No**

Number of brothers:_____ Number of sisters:_____

Do you have any half siblings? **Yes** or **No**

Number of brothers:_____ Number of sisters:_____

What is your birth order (e.g. 1st, 2nd, 3rd, etc. child)? _____

Please list any other siblings you have (adopted, step-sibling, other family member raised as a sibling):

_____

Do any of your siblings have any major illnesses? **Yes** or **No**

If yes, please list: _____

Is there any other important family history? **Yes** or **No**

If yes, please list: _____

_____

_____

_____

_____

_____



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## Social History

Are you married? **Yes** or **No**

How many times have you been **married**? _____

Are you **divorced** or **widowed**? **Yes** or **No** If yes, please indicate which: _____

Do you have children? **Yes** or **No**

How many sons? _____ What are their ages? _____

How many daughters? _____ What are their ages? _____

What is / was your **occupation**? _____

Are you **retired**? **Yes** or **No**

Have you served in the military? **Yes** or **No**

**Where** were you born? _____

**Where** have you spent most of your life? _____

**When** did you move to Colorado if you are not a native? _____

In what **religion** were you raised? _____

Do you have any current religious affiliation? _____

Do you consider yourself spiritual? **Yes** or **No**

What is your highest level of education? _____

Have you suffered any type of abuse? _____

- ☐ Emotional
- ☐ Mental
- ☐ Physical
- ☐ Sexual (including inappropriate behavior)

If yes, from whom and when: _____

Have you been in **counseling**? **Yes** or **No**

Did you have a happy **childhood**? **Yes** or **No**

Do you **smoke**? **Yes** or **No**

At what age did you start? _____

**How much** do / did you smoke? _____

How many years? _____

**When** did you quit? _____

Did you chew **tobacco**? _____

Do you drink any **alcohol**, **wine**, or **beer**? _____

How much per week, month, year? _____

Do you currently use any recreational drugs? **Yes** or **No**

Did you use any recreational drugs regularly in the past? **Yes** or **No**

Do you have any tattoos? **Yes** or **No** If **yes**, how many? _____

Do you have any body piercing? **Yes** or **No** If **yes**, where? _____

Have you ever received any type of transfusions? **Yes** or **No** If **yes**, when? _____

Have you ever been checked for Hepatitis C? **Yes** or **No** Are you Hep C positive? **Yes** or **No**



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Do you drink any caffeine? **Yes** or **No** If yes, how much? _____

Do you drink any soda products? **Yes** or **No** If yes, how much? _____

What brand do you drink? _____

Do you wear a seatbelt? **Yes** or **No**

Do you exercise? **Yes** or **No** Do you have an active job? **Yes** or **No**

If yes, what form of exercise? _____

How often do you exercise per week? _____

What is your blood type? A B O AB Rh+ Rh-

Please indicate if you have been immunized against the following (including date):

- ☐ Tetanus _____/_____/_____
- ☐ Flu _____/_____/_____
- ☐ Hepatitis A _____/_____/_____
- ☐ Hepatitis B _____/_____/_____
- ☐ MMR (2nd) _____/_____/_____
- ☐ Pneumovax _____/_____/_____
- ☐ I am against immunizations
- ☐ HPV Vaccine ____/____/_____
- ☐ Shingles Vaccine ____/____/_____
- ☐ Meningitis Vaccine ____/____/_____
- ☐ Typhoid Vaccine ____/____/_____
- ☐ Yellow Fever Vaccine ____/____/_____

Have you been pregnant? **Yes** or **No** If yes, how many times? _____

Do you have any children? **Yes** or **No** If yes, how many? _____

How old were you when your periods started? _____

How old were you when your periods ended? _____

Are you currently sexually active? **Yes** or **No**

Do you or your partner use birth control? **Yes** or **No** What type? _____

When was your last:

- ☐ Pap smear ____/____/_____
- ☐ Mammogram ____/____/_____
- ☐ Breast exam ____/____/_____
- ☐ Blood work ____/____/_____
- ☐ Rectal exam ____/____/_____
- ☐ Colonoscopy ____/____/_____
- ☐ Testicular exam ____/____/_____
- ☐ Prostate exam ____/____/_____
- ☐ EKG ____/____/_____
- ☐ Chest X-Ray ____/____/_____
- ☐ Urinalysis ____/____/_____
- ☐ Bone Density Test ____/____/_____
- ☐ Pelvic Ultrasound ____/____/_____
- ☐ Breast Ultrasound ____/____/_____
- ☐ Thermogram ____/____/_____
- ☐ Breast MRI ____/____/_____
- ☐ Abdominal Ultrasound ____/____/_____
- ☐ EGD ____/____/_____
- ☐ MRI ____/____/_____
- ☐ CT Scan ____/____/_____
- ☐ Echocardiogram ____/____/_____
- ☐ Cardiac CT Scan ____/____/_____
- ☐ Holter Monitor ____/____/_____
- ☐ X-rays ____/____/_____

Have any of the above been abnormal? **Yes** or **No**

Has anything changed since your last Physical exam (e.g. major illness, surgery, or stressors (**death of family member** or **friend**, **marriage**, **job** or **birth**)? **Yes** or **No** If yes, please describe: _____

_____

_____



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