Name: _____ Date: _____

Expectations of Services

1. *What do you believe to be your top 5 medical problems?*
   a.
   b.
   c.
   d.
   e.

2. *Past surgeries and allergies:*

3. *What would be an **expected** results, with help from PATH Medical?*

   *A **miraculous** one?*

4. *How quickly do you expect results?*

5. *How do you expect it to be done?*
   ***A.** Medications **B.** Hormones **C.** Nutrients **D.** Diet*

6. *How would you like to feel and look in 10 years?*
   a.
   b.
   c.
   d.

7. *Please address any concerns you may have immediately so that we may rectify! We are here to make a difference in your life!!!*

304 Park Ave. South, 6th Floor
Entrance on 23rd Street
New York, NY 10010
tel 212.213.6155
fax 212.213.6188
www.pathmed.com

Place for Achieving Total Health

304 Park Avenue South, 6th Floor, New York, NY 10010

MEDICAL HISTORY

NAME _____ **DATE** _____

Please Mark "P" for any symptoms you had for the past 10 years and YES for current symptoms.

CONSTITUTIONAL

Good general health	YES	NO
Recent weight change	YES	NO
Fever	YES	NO
Fatigue	YES	NO
Headaches	YES	NO
Night sweats	YES	NO

NEUROLOGICAL

Frequent or recurring headaches	YES	NO
Light headed or dizzy	YES	NO
Convulsions or seizures	YES	NO
Numbness or tingling sensations	YES	NO
Tremors	YES	NO
Paralysis	YES	NO
Seizures	YES	NO
Stroke	YES	NO
Loss of balance	YES	NO
Loss of strength	YES	NO
Falls	YES	NO
Loss of consciousness	YES	NO
Difficulty speaking	YES	NO

PSYCHIATRIC

Memory loss or confusion	YES	NO
Nervousness	YES	NO
Depression	YES	NO
Sleep problems	YES	NO
Panic attacks	YES	NO
Suicidal thoughts / ideation	YES	NO

EYES

Eye disease or injury	YES	NO
Wear glasses / contact lens	YES	NO
Blurred/double vision	YES	NO
Glaucoma	YES	NO
Floaters	YES	NO
Loss of vision	YES	NO
Inability to focus	YES	NO

ENT

Hearing loss	YES	NO
Snoring	YES	NO
Ringing in the ears	YES	NO
Sinus problems	YES	NO
Nose bleeds, congestion, pain	YES	NO
Mouth sores, pain	YES	NO
Bleeding gums	YES	NO
Bad breath or bad taste	YES	NO
Sore throat or voice change	YES	NO
Swollen glands in neck	YES	NO
Pain in ears	YES	NO

CARDIOVASCULAR

Heart trouble	YES	NO
Chest pain	YES	NO
Sudden heart beat change	YES	NO
Swelling of feet, ankles or hands	YES	NO
Shortness of breath	YES	NO
Lightheadedness	YES	NO

RESPIRATORY

Frequent coughing	YES	NO
Spitting up blood	YES	NO
Shortness of breath	YES	NO
Asthma or wheezing	YES	NO
Chest pain	YES	NO
Sputum production	YES	NO

GASTROINTESTINAL

Loss of appetite	YES	NO
Change in bowel movement	YES	NO
Nausea or vomiting	YES	NO
Frequent diarrhea	YES	NO
Painful bowel movements / constipation	YES	NO
Blood in stool	YES	NO
Stomach pain	YES	NO
Black stool	YES	NO
Heartburn	YES	NO
Difficulty swallowing	YES	NO

Last Colonoscopy and findings _____

GENITOURINARY

Frequent urination	YES	NO
Burning or painful urination	YES	NO
Blood in urine	YES	NO
Change of force of stream when urinating	YES	NO
Incontinence or dribbling	YES	NO
Kidney stones	YES	NO
Male – testicle pain/swelling	YES	NO
Female – pain with periods	YES	NO
Female – irregular periods	YES	NO
Female –vaginal discharge	YES	NO

Female - Last Menstrual Period _____

Female – # pregnancies_____# miscarriages_____

Female –Last PAP Smear and findings _____

Female – Last Mammogram and findings _____

Changes in sexual functioning	YES	NO
Breast tenderness, discharge, lumps	YES	NO
Genital sores	YES	NO

ENDOCRINE

Glandular or hormone problem	YES	NO
Thyroid disease	YES	NO
Excessive thirst or urination	YES	NO
Heat or cold intolerance	YES	NO
Dry skin	YES	NO
Change in hat or glove size	YES	NO
Excessive hair growth	YES	NO
Darkening of the skin	YES	NO

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	YES	NO
Easily bruise or bleed	YES	NO
Anemia	YES	NO
Phlebitis	YES	NO
Past transfusion	YES	NO
Enlarged glands	YES	NO
Excessive bleeding	YES	NO

MUSCULOSKELETAL

Joint pain	YES	NO
Joint stiffness or swelling	YES	NO
Weakness of muscles or joints	YES	NO
Muscle pain or cramps	YES	NO
Back pain	YES	NO
Cold extremities	YES	NO
Difficulty in walking	YES	NO
Loss of muscle mass	YES	NO
Involuntary painless muscle movement	YES	NO
Difficulty rising from a low chair	YES	NO
Difficulty negotiating stairs	YES	NO

SKIN

Dry Skin	YES	NO
Rash or itching	YES	NO
Change in skin color	YES	NO
Change in hair or nails	YES	NO
Varicose veins	YES	NO
Skin lesions/moles	YES	NO

List any MEDICATIONS you are CURRENTLY taking:

_____

_____

_____

Known drug allergies: _____

_____

_____

_____

Patient's Signature _____

Name of person completing history if other than patient: _____

Name: _____ Date: _____

Please Check Off All Medications You Have Been On In the Past

Anti-Depressants

Add Max Dose (If you remember)

- Zoloft (sertraline) ____
- Lexapro (escitalopram) ____
- Prozac (fluxetine) ____
- Celexa (citalopram) ____
- Cymbalta (duloxetine) ____
- Wellbutrin (bupropion) ____
- Effexor (venlafaxine) ____
- Remeron (mirtazapine) ____
- Buspar (buspirone) ____
- Anafranil (clomipramine) ____
- Paxil (paroxetine) ____

Antipsychotics

- Abilify (aripiprazole) ____
- Clozaril (clozapine) ____
- Risperdal (risperidone) ____
- Mellaril (thioridazine) ____
- Navane (thiothixene) ____
- Prolixin (fluphenazine) ____
- Geodon (ziprasidone) ____
- Haldol (haloperidol) ____
- Seroquel (quetiapine) ____
- Orap (pimozide) ____
- Zyprexa (olanzapine) ____

Stimulants

- Adderall (d,l amphetamine) ____
- Ritalin-(d,l methylphenidate) ____
- Provigil (modafinil) ____
- Strattera (atomoxetine) ____
- Concerta -(d,l methylphenidate) ____

Anticonvulsants

- Keppra (levetiracetam) ____
- Dilantin (phenytoin) ____
- Lamictal (lamotrigine) ____
- Topax (topiramate) ____
- Phenobrbital (solfotone) ____
- Gabatrol (tiagabine) ____
- Lyrica (pregabalin) ____
- Trileptal (oxcarbazepine) ____
- Felbatol (felbamate) ____
- Depakote (valproic acid, divalproex) ____
- Neurontin (gabapentin) ____
- Eskalith, Lithobid-Lithium ____
- Bontril (phendimetrazine) ____

Benzodiazepines

- Xanax (alprazolam) ____
- Ativan (lorazepam) ____
- Valium (diazepam) ____
- Klonopin (clonazepam) ____
- Halcion (triazolam) ____

Weight Loss

- Tenuate (diethylpropion) ____
- Adipex (phentermine) ____
- Xenical (orlistat) ____
- Prelu-2-phendimetrazine ____
- Meridia (sibutramine) ____
- Revia/vivitrol (naltrexone) ____