CHICAGO ANTI-AGING INSTITUTE

16622 W. 159th Street, Suite 500, Lockport, IL 60441

Confidential Comprehensive Health History

In order for us to provide you with the best possible health care, we *must* have a complete and accurate health history. Please take a few minutes to fill out the following pages. If you need help with any portion of this history please ask a member of our staff and they will be happy to assist you.

Thank you,

Name_____
(Please Print)

Date _____/_____/_____

CSI #_____
(Please leave this space blank)

Please list any other doctors you have seen in the past for the injury or symptoms you are having now. Also, please list any other doctors you are currently seeing for any condition.

1) Dr. _____ Specialty: _____

Phone #: (_____)_____ Date of first visit: _____/_____/_____ Date of last visit: _____/_____/_____

Reason for visit: _____

Were ❑ X-Rays ❑ MRI taken? ❑ No ❑ Yes, which body part? _____

The X-Rays revealed:_____

Was treatment received? ❑ No ❑ Yes, describe:_____

Are you currently being treated? ❑ No ❑ Yes Did treatments benefit you? ❑ No ❑ Yes

Were there any follow up instructions? _____

2) Dr. _____ Specialty: _____

Phone #: (_____)_____ Date of first visit: _____/_____/_____ Date of last visit: _____/_____/_____

Reason for visit: _____

Were ❑ X-Rays ❑ MRI taken? ❑ No ❑ Yes, which body part? _____

The X-Rays revealed:_____

Was treatment received? ❑ No ❑ Yes, describe:_____

Are you currently being treated? ❑ No ❑ Yes Did treatments benefit you? ❑ No ❑ Yes

Were there any follow up instructions? _____

3) Dr. _____ Specialty: _____

Phone #: (_____)_____ Date of first visit: _____/_____/_____ Date of last visit: _____/_____/_____

Reason for visit: _____

Were ❑ X-Rays ❑ MRI taken? ❑ No ❑ Yes, which body part? _____

The X-Rays revealed:_____

Was treatment received? ❑ No ❑ Yes, describe:_____

Are you currently being treated? ❑ No ❑ Yes Did treatments benefit you? ❑ No ❑ Yes

Were there any follow up instructions? _____

Please list any surgeries or hospitalizations you have had. _____

_____

Please list any medications that you are currently taking (if you have your medications already written on a separate sheet of paper, please give it to the front desk to photo copy for your records). _____

_____

Please list and describe any significant traumas you have had. (Auto accidents, falls etc.) _____

_____

Please list any known allergies that you have.

OCCUPATIONAL HISTORY: I work: ❑ Full Time ❑ Part Time ❑ Retired ❑ On temporary disability ❑ On permanent disability ❑ Homemaker ❑ Unable To Work ❑ Student

Please give a brief description of your current / most recent employment responsibilities. _____

SOCIAL HISTORY: **Your Current Age**_____ **Height**_____ **Weight**_____

Education level: ❑ Grade school ❑ High school ❑ Undergraduate ❑ Graduate ❑ Postgraduate

Caffeine: ❑ No ❑ Yes In what form? (i.e. coffee, soft drinks)_____ How much per day_____

Tobacco: ❑ Never ❑ Present - since _____ ❑ Past - from _____ to _____

In what form?_____ How much per day?_____pack(s)

Alcohol: ❑ Never ❑ Light ❑ Moderate ❑ Heavy ❑ Currently ❑ In the past, currently not drinking

Recreational Drugs: ❑ Never ❑ Present - since _____ ❑ Past - from _____ to _____

What kind?_____

EXERCISE & DIET HISTORY:

How many hours do you sleep each night? _____ What is the quality of that sleep? ❑Poor ❑Fair ❑Good ❑Excellent

Please list any vitamins, herbs or other dietary supplements you are currently taking. _____

FAMILY HISTORY:

Please list the names and age of the immediate members of your family. Spouse _____age ____

Child 1_____age_____, Child 2_____ age_____, Child 3_____ age ____

Please list any immediate family members who are deceased, how they died, and at what age. _____

WOMEN ONLY: Are you pregnant at this time? ❑ No ❑ Yes **Have you ever been pregnant?** ❑ No ❑ Yes

Have you ever had a cesarean section? ❑ No ❑ Yes

Please describe any complications you have had during or immediately following pregnancy. _____

Date of your last period _____ **/**_____ **/**_____ **My cycle is** _____ **days.** Flow: ❑Light ❑Medium ❑Heavy ❑Post Menopause

Date of last pelvic exam. _____/_____/_____ **Date of last Pap test** _____ **/**_____ **/**_____ **Results:**❑ Positive ❑ Negative

Have you ever been on birth control pills? ❑ No ❑ Past - from _____ to _____ ❑ Present - since _____

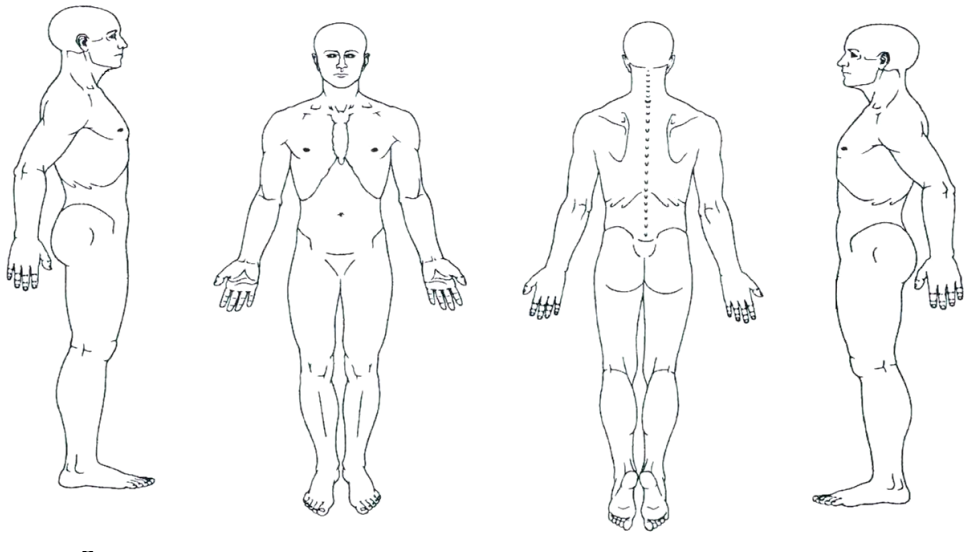
When was your last Mammogram? _____ /_____ /_____ ❑ Never had one

Masses or lumps ever found in your breasts? ❑ No ❑ Yes If yes, what was the outcome? _____

Please Indicate On The Drawings Below Where Your Pain Is Generally Located

Briefly Describe Your Current Symptom(s) Here:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____



Doctor's Notes: _____

_____

_____

_____

REVIEW OF SYSTEMS: Please check all the items that apply to you. Leave the item blank if you have never experienced any of the conditions.

	Currently	Past	MUSCULOSKELETAL	Currently	Past
Sore Muscles	❑	❑	Rheumatoid Arthritis	❑	❑
Poor Posture	❑	❑	Broken Bones	❑	❑
Scoliosis	❑	❑	Bone or Joint Disease	❑	❑
Sciatica	❑	❑	Harrington rods	❑	❑
Tendonitis	❑	❑	Spondylolisthesis	❑	❑
Stiff Joints	❑	❑	Joint Replacements	❑	❑
Swollen Joints	❑	❑	Disc Herniation in Neck	❑	❑
Bursitis	❑	❑	Disc Herniation in Upper Back	❑	❑
Arthritis	❑	❑	Disc Herniation in Lower Back	❑	❑

Doctor's Notes:

_____

_____

_____

❑ Verbally reviewed and discussed with patient. _____

	Currently	Past	RESPIRATORY	Currently	Past
Lung Problems	❑	❑	Pneumonia	❑	❑
Difficult Breathing	❑	❑	Whooping Cough	❑	❑
Persistent Cough	❑	❑	Tuberculosis	❑	❑
Coughing Phlegm	❑	❑	Pleurisy	❑	❑
Coughing Blood	❑	❑	Asthma	❑	❑
Wheezing	❑	❑	Bronchitis	❑	❑

Doctor's Notes:

_____

_____

❑ Verbally reviewed and discussed with patient. _____

	Currently	Past	GENITO-URINARY	Currently	Past
Kidney Problems	❑	❑	Bladder Trouble	❑	❑
Kidney Stone	❑	❑	Frequent Urination	❑	❑
Endometriosis	❑	❑	Excessive Urination	❑	❑
Gonorrhea	❑	❑	Scanty Urination	❑	❑
Syphilis	❑	❑	Painful Urination	❑	❑
HIV / AIDS	❑	❑	Prostate Problems	❑	❑
Chlamydia	❑	❑	Trouble Start / Stop Urination	❑	❑
Herpes	❑	❑			

Doctor's Notes:

_____

_____

_____

❑ Verbally reviewed and discussed with patient. _____

	Currently	Past	NERVOUS SYSTEM	Currently	Past
Loss of Feeling	❑	❑	Nervousness	❑	❑
Paralysis	❑	❑	Forgetfulness	❑	❑
Ringing in Ears	❑	❑	Fatigue	❑	❑
Dizziness	❑	❑	Depression	❑	❑
Fainting	❑	❑	Tension	❑	❑
Loss of Balance	❑	❑	Confusion	❑	❑
Irritability	❑	❑	Muscle Weakness	❑	❑
Convulsions	❑	❑	Nervous Breakdown	❑	❑
Epilepsy	❑	❑	Mental Disorder	❑	❑
Meningitis	❑	❑	Stroke / CVA	❑	❑
			Muscle Jerking / Tremors	❑	❑

Doctor's Notes:

❑ Verbally reviewed and discussed with patient. _____

	Currently	Past	CARDIOVASCULAR	Currently	Past
Heart Problems	❑	❑	Shortness of Breath	❑	❑
Chest Pain	❑	❑	Vericose Veins	❑	❑
Pain Over Heart	❑	❑	Hemorrhoids	❑	❑
Rapid Heart Beat	❑	❑	Arterial Problems	❑	❑
Pace Maker	❑	❑	Blood Pressure Problems	❑	❑
Anemia	❑	❑	Arm, Leg or Ankle Swelling	❑	❑
Poor Circulation	❑	❑	Chronic / Excessive Heartburn	❑	❑
			Trouble Breathing Laying Down	❑	❑

Doctor's Notes:

❑ Verbally reviewed and discussed with patient. _____

	Currently	Past	GASTROINTESTINAL	Currently	Past
Excessive Thirst	❑	❑	Liver Trouble	❑	❑
Diabetes	❑	❑	Gall Bladder Trouble	❑	❑
Excessive Hunger	❑	❑	Hernia	❑	❑
Poor Appetite	❑	❑	Ulcer	❑	❑
Nausea	❑	❑	Colon Trouble	❑	❑
Vomiting Food	❑	❑	Stomach Trouble	❑	❑
Vomiting Blood	❑	❑	Indigestion	❑	❑
Abdominal Pain	❑	❑	Jaundice	❑	❑
Diarrhea	❑	❑	Food Poisoning	❑	❑
Constipation	❑	❑	Drug Poisoning	❑	❑
Black Stool	❑	❑	Chemical Poisoning	❑	❑
Painful Bloody Stool	❑	❑	Rapid Weight Gain	❑	❑
Painless Bloody Stool	❑	❑	Unexplained Weight Loss	❑	❑

Doctor's Notes:

❑ Verbally reviewed and discussed with patient._____

	Currently	Past	OTHER DISEASES	Currently	Past
Measles	❑	❑	Diphtheria	❑	❑
German Measles	❑	❑	Scarlet Fever	❑	❑
Mumps	❑	❑	Polio	❑	❑
Chicken Pox	❑	❑	Cancer	❑	❑
Shingles	❑	❑	Eczema	❑	❑
Influenza	❑	❑	Eye Problems	❑	❑
Frequent Colds	❑	❑	Ear / Nose / Throat Problems	❑	❑
				❑	❑
			New / Growing / Changing lumps, moles or lesions		

Doctor's Notes:

❑ Verbally reviewed and discussed with patient. _____

The information contained on this history form, whether written or verbal, is truthful and accurate to the best of my knowledge.

Signature of patient: _____ Date_____

This history was read and reviewed with the patient by Dr. (print) _____

Signature of doctor: _____ Date_____