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Please DO NOT wear perfumes, aftershaves or scents to the office. Some patients are allergic.

Medical and Health History

Fill out this form and bring it with you to your appointment. Do not mail it.
Please bring all medications and supplements to your appointment

Name: _____ Age _____ Sex _____ Marital status _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

e-mail _____ Birthdate _____

Occupation _____ Past occupations? _____

Children: number of girls _____ ages _____ boys _____ ages _____

Name of spouse or partner _____ Age _____ Occupation now or past _____

Name/address of primary care physician _____

Who referred you, or how did you learn of us? _____

PLEASE DESCRIBE YOUR MAJOR PROBLEMS AND/OR SYMPTOMS. (If none, please write your reason for seeking this consultation.) Please be clear and concise to help us help you. Include when the symptom first appeared. Write what you can in the space provided. If you need more space, add a separate sheet of paper:

Please bring recent medical records, if possible, especially lab tests or hospital discharge summaries.

Name: _____

What diagnosis or explanations have you been given in the past? _____

When is the last time you were in really good health? _____ / _____ / _____

Do you see yourself in good health again in the future? Yes or No

Please circle the following: Taking everything into consideration, are you:

much worse / worse / the same / better / much better than six months ago?

What has happened to you as a result of your illness? _____

WHAT DO YOU WANT TO ACHIEVE DURING YOUR VISIT? _____

What are your long-term goals from coming to this office? _____

Other household members now living with you (Include family members, non-family members and pets)

Name	Relationship	Age	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your height _____ Current weight _____ Lowest adult weight _____

Highest _____ Desired _____

DO YOU SMOKE? _____ How much per day? _____ For how long have you smoked? _____

Did you ever smoke? _____ How much? _____ For how long? _____

When did you stop? _____ Do you live or work closely with a smoker? _____

Name: _____

ALCOHOL USE? specify what type, how much, and how frequently _____

Do you drink to excess? _____ Did you ever drink a lot of alcohol? _____ When did you stop? _____

RECREATIONAL DRUG USE? specify type and frequency _____

CAFFEINE USE: How much of each of the following do you consume? Regular coffee? _____

Tea? _____ Chocolate or cocoa? _____ Colas or other caffeinated soft drinks? _____

Non-prescribed medications (laxatives, aspirin, antihistamines, decongestants, stimulants, etc.) _____

Prescribed medications (names and doses) _____

ALLERGIES to medications (name of the drug and type of reaction) _____

Other ALLERGIES or SENSITIVITIES (foods, pollens, animals, chemicals, etc.) _____

Do you EXERCISE regularly? _____ Type of exercise? _____

How often? _____ length of sessions? _____ Do you sweat? _____

Do you do any STRESS REDUCTION or RELAXATION such as meditation, yoga, prayer,

Self-hypnosis, etc? _____ If yes, what types? _____ How often? _____

Length of sessions? _____

Do you consider yourself to be under low / moderate / high levels of stress? (circle one)

SLEEP: Hours / night? _____ Restless or restless? _____ What time do you retire? _____

Do you wake during the night? _____ Do you feel rested when you get up in the morning? _____

What are your hobbies or other life interests? _____

Have you lived or traveled outside the United States? If so, where and when? _____

Name: _____

PAST HISTORY: Circle any of the following childhood illnesses that you had: Colic, Eczema, Asthma, Polio, Allergies, Bronchitis, Pneumonia, Meningitis, Rheumatic fever, Recurrent colds, Ear infections, Thrush, German measles, Bedwetting, Tonsillectomy, Persistent diaper rashes, Learning disabilities, Hyperactivity, Measles, Mumps, Chicken pox, Mononucleosis, Other _____

List other past medical problems as a child or adult (give dates and specifics) _____

Have you ever been on frequent or prolonged antibiotic therapy, such as erythromycin, penicillin, tetracycline, sulfa drugs, Flagyl, etc? _____

List major hospitalizations: Give dates, locations, reasons (diagnoses), lengths of hospital stays, any surgeries. _____

FAMILY HISTORY: Name age sex (M/F) living/deceased (L/D) Health Problems/Cause of death

Father _____

Mother _____

Brothers/Sisters

1. _____

2. _____

3. _____

4. _____

5. _____

Spouse/
Partner

Children

1. _____

2. _____

3. _____

4. _____

Name: _____

SYMPTOM AND SYSTEM REVIEW: Write all the appropriate letters in the left hand columns. DO NOT fill in anything if the problem does not apply to you.

Write "C" for a current problem; "I" if it is an intermittent problem, and "P" for a past problem.

- | | | |
|---|--|--|
| <input type="checkbox"/> headaches | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> weakness |
| <input type="checkbox"/> neck lumps or swelling | <input type="checkbox"/> skipped heartbeats | <input type="checkbox"/> painful feet |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> racing heart | <input type="checkbox"/> leg cramps |
| <input type="checkbox"/> dizzy spells | <input type="checkbox"/> chest pain or pressure | <input type="checkbox"/> trembling or tremors |
| <input type="checkbox"/> vertigo | <input type="checkbox"/> swollen feet or ankles | <input type="checkbox"/> seizures or epilepsy |
| <input type="checkbox"/> blackouts or fainting | <input type="checkbox"/> difficulty breathing at night | <input type="checkbox"/> numbness or tingling |
| <input type="checkbox"/> blurry vision | <input type="checkbox"/> varicose veins or phlebitis | <input type="checkbox"/> skin tumors |
| <input type="checkbox"/> double vision | <input type="checkbox"/> recurring indigestion | <input type="checkbox"/> dry skin |
| <input type="checkbox"/> cataracts | <input type="checkbox"/> nausea or vomiting | <input type="checkbox"/> acne |
| <input type="checkbox"/> eye pain or itching | <input type="checkbox"/> intestinal gas/flatulence | <input type="checkbox"/> eczema |
| <input type="checkbox"/> watery eyes or redness | <input type="checkbox"/> belching | <input type="checkbox"/> skin rashes |
| <input type="checkbox"/> hearing difficulties | <input type="checkbox"/> bloating | <input type="checkbox"/> psoriasis |
| <input type="checkbox"/> earaches or drainage | <input type="checkbox"/> abdominal pain or cramps | <input type="checkbox"/> dandruff or seborrhea |
| <input type="checkbox"/> noises or ringing in ears | <input type="checkbox"/> constipation | <input type="checkbox"/> hives |
| <input type="checkbox"/> recurrent ear infections | <input type="checkbox"/> diarrhea or loose stools | <input type="checkbox"/> itching or burning skin |
| <input type="checkbox"/> dental problems/decay | <input type="checkbox"/> rectal itching | <input type="checkbox"/> easy bruising |
| <input type="checkbox"/> sore or bleeding gums | <input type="checkbox"/> blood with stools | <input type="checkbox"/> hypothyroid (low) |
| <input type="checkbox"/> sore tongue | <input type="checkbox"/> black stools | <input type="checkbox"/> hyperthyroid (high) |
| <input type="checkbox"/> coated tongue | <input type="checkbox"/> pain in rectum | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> loss of taste or smell | <input type="checkbox"/> jaundice | <input type="checkbox"/> feel excessively warm |
| <input type="checkbox"/> sores in or around mouth | <input type="checkbox"/> hepatitis/pancreatitis | <input type="checkbox"/> feel excessively cold |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> colitis | <input type="checkbox"/> loss of appetite |
| <input type="checkbox"/> cold sores or fever blisters | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> constant hunger |
| <input type="checkbox"/> sinus or nasal congestion | <input type="checkbox"/> diverticulitis/diverticulosis | <input type="checkbox"/> fatigue |
| <input type="checkbox"/> runny nose | <input type="checkbox"/> frequent urination | <input type="checkbox"/> night sweats |
| <input type="checkbox"/> frequent colds | <input type="checkbox"/> brown or red urine | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> nasal polyps | <input type="checkbox"/> decreased force of urine | <input type="checkbox"/> low blood sugar |
| <input type="checkbox"/> sore throats | <input type="checkbox"/> frequent urge to urinate | <input type="checkbox"/> nervousness or anxiety |
| <input type="checkbox"/> swollen glands | <input type="checkbox"/> incontinence | <input type="checkbox"/> depression |
| <input type="checkbox"/> recurrent fevers or chills | <input type="checkbox"/> difficulty starting urination | <input type="checkbox"/> suicidal thoughts |
| <input type="checkbox"/> hoarse voice | <input type="checkbox"/> kidney or bladder infection | |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> venereal disease | --MEN ONLY-- |
| <input type="checkbox"/> wheezing | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> painful testicles |
| <input type="checkbox"/> coughing | <input type="checkbox"/> aching muscles or joints | <input type="checkbox"/> hernia |
| <input type="checkbox"/> coughing up blood | <input type="checkbox"/> arthritis | <input type="checkbox"/> prostrate problems |
| <input type="checkbox"/> chest colds or pneumonia | <input type="checkbox"/> joint stiffness | <input type="checkbox"/> sexual dysfunction |
| <input type="checkbox"/> heart murmur | <input type="checkbox"/> back or neck pain | |

LIVING ENVIRONMENT: (circle appropriate terms) urban, suburban, country, seaside, lakeside

Type of heat _____ humidifier? _____ wood stove? _____

Type of insulation _____ Is the cellar dry, damp, musty, dusty? _____

Is the house old or new? _____ Has it been treated for pests? _____ What kind? _____

Do you use feather or down covers, comforters, or jackets? _____ Do you have an air filter or cleaner? _____

Are there animals at home or places you visit frequently? _____ What kind? _____

Do you use strong chemical cleaners, solvents, paints, etc? _____ What? _____

Name: _____

DIET SURVEY Please take the time to answer these questions specifically and concisely.

What do you normally eat or drink between meals? _____

Do you binge? _____ Use food for reward or escape? _____ If so, what foods do you use, and how often? _____

What foods would be most difficult for you to give up? _____

Do you have specific food cravings? _____ What foods? _____

What work or scheduling considerations might create difficulties for you in trying to change your eating or other health habits? _____

Any known food sensitivities? _____

Please rate the following according to the appropriate frequency of your personal habits.

F=frequent, at least once a day; **O** = often, several times a week; **Occ** =occasional, once a week or less; **S** =seldom, once or twice a month or less; **N** =never, almost total avoidance

- | | | |
|--|--|---|
| ____ alcoholic beverages | ____ chicken, turkey--circle: free-range, regular | ____ salt |
| ____ eat at restaurants | ____ fresh fish--wild or farm raised | ____ herbs, fresh and dried, spices |
| ____ eat at fast food restaurants | ____ processed luncheon meat | ____ water--circle: tap, filtered bottled |
| ____ pastries, cookies, candies, ice cream, other sweets | ____ fresh raw fruit | ____ artificial sweeteners |
| ____ add sugar to coffee, tea, cereal, other foods | ____ fresh vegetables, raw or cooked | ____ eat if bored or depressed |
| ____ colas, other soft drinks | ____ salads | ____ hurried or rushed meals |
| ____ instant breakfasts, pop tarts, donuts, muffins | ____ whole grains or whole grain breads | ____ stuff yourself |
| ____ cold breakfast cereals | ____ white bread or white flour products | ____ swallow before chewing well |
| ____ caffeine drinks (coffee, tea, cola, chocolate) | ____ beans and legumes (lentil, kidney, chickpea, etc) | ____ sneak or hide foods |
| ____ deep fried food | ____ yogurt--circle: whole, lowfat, plain or flavored | ____ read and understand food labels |
| ____ margarine of <u>any</u> type | ____ milk--circle: whole, lowfat, skim | ____ adequate fiber in diet |
| ____ whole grain hot cereals | ____ cheese | ____ shop at health food stores |
| ____ meat (beef, veal, pork, ham, lamb, liver) | ____ egg (circle): regular or free-range | ____ buy organic/grow your own vegetables |

Diet Log

Please write down what you eat and drink for a week. This includes juice, coffee, alcohol. If you're attempting to follow any particular diet, please indicate that in the space below the table, ie. Swank diet, Atkins.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Snack							