Dean Chier, MD

Please print This information will be contained in your confidential medical history **Please print**

Patient Name (first, middle, last)	Date of Birth & Age:	Today's Date:

Height: ___________ Weight _________ Weight at age 20 __________ Weight change last year: gain __________ lbs. lost _________ lbs.

DIET: Fast Food___ All American___ Vegetarian___ Balanced___ Other _______________________________

EXERCISE: Never Occasional Moderate Often Favorite types:

SMOKING: Packs per day __________ Number of years __________ Years stopped _________ Pipe Cigar Chew

ALCOHOL: Never Occasional Moderate Heavy Alcohol Problem? Y N How much each week?

CAFFEINE: Coffee: _____ cups per day Tea: _____ cups per day Energy Drinks: _____ cans per day

OCCUPATIONAL EXPOSURES: _____ Mold _____ Heavy Metals _____ Other (describe)

PAST HISTORY

Major Illnesses (include names & dates):

Previous Hospitalizations or Surgeries:

WELL BEING

Goals for Health:

What practices or activities do you use to sustain your health and well-being?

Who do you turn to for support? Who are in your community?

Who lives in your household?

What causes stress for you?

MEDICATIONS

Please circle drugs presently used and explain frequency of use (daily, weekly, etc.)

Sleeping pill	Birth control pill	Heart pill	Laxatives
Tranquilizer	Hormone Replacement	Blood pressure pill	Antibiotics
Anti-Depressant	Allergy medicine(s)	Nitroglycerin	Other medication
Pain pill/ Muscle relaxant	Nose sprays	Water pill (diuretic)	Vitamins
Diabetes pill	Cortisone/steroids	Blood thinner	Supplements
Insulin	Asthma medication	Thyroid medication	Marijuana
		Stomach medication	“Hard Drugs”

ALLERGIES

Food sensitivities:

Drug allergies/Type of reaction:

FAMILY HISTORY

Diabetes	Thyroid disease
Heart disease	Mental Illness
High blood pressure	Alcoholism
High Cholesterol	Suicide
Stroke	Cancer

CHILDRENS AGES/NAMES

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REASONS FOR SEEING DR. CHIER

Please state the chief concerns, main problem, or issues you would like to address:

REVIEW of SYSTEM

Check if you have any symptoms or problems to any important or significant degree

Date of Last:	Cataract	Swallowing trouble	Psychiatrist seen
Physical Exam:	Frequent cough	Indigestion	High blood sugar
Dental Exam:	Cough phlegm	Heartburn	Sugar in urine
Eye Exam:	Cough blood	Nervous stomach	Hypoglycemia
Chest X-ray:	Frequent chest colds	Ulcers	Thyroid trouble
Electrocardiogram:	Bronchitis	Vomiting blood	Bladder problems
Urinary or bladder infection:	Pneumonia	Black or bloody stools	Kidney infection
Colonoscopy:	Shortness of breath	Rectal bleeding	Kidney trouble
Tired all the time	Asthma/wheezing	Abdominal pain	Kidney stone
Don't feel well	Hayfever/Allergies	Nervous or spastic colon	Difficulty with urine
Weakness	Pleurisy	Colitis	Protein or blood in urine
Weight problem	Chest pain	Diarrhea	Sexually transmitted disease
Ankle/leg swelling	Heart trouble	Constipation	Skin rash
Lack of exercise	Heart murmur	Change in bowel habits	Skin trouble
Headache	Heart palpitation/racing	Hemorrhoids	Skin Allergy
Migraine	Chest tightness/pressure	Gall bladder trouble	Food avoidance or intolerance
Fainting	Angina	Hepatitis	Bleed or bruise easily
Dizziness	Jaw Pain	Liver disease	Anemia
Epilepsy/seizure	Enlarged heart	Hernia	Blood disease
Ear/hearing problem	Rheumatic fever	Nervous	Sexual difficulty
Ringing in the ears	Leg pain on walking	Tense/irritable	**MEN ONLY:**
Stuffy nose	Varicose veins	Bored	Discharge from penis
Nose bleeds	Phlebitis	Depressed	Prostate trouble
Sinus trouble	Arthritis/joint pain	Trouble sleeping	Stream weak or slow
Hoarseness	Gout	Relationship problems	Swelling or pain in testes
Glasses	Neck pain	Job problems	Date of vasectomy:
Vision/eye trouble	Back pain or trouble	Personal problems	
Glaucoma	Bursitis/tendonitis	Nervous breakdown	

WOMEN ONLY:

Age menstruation began: ______ Periods: ____Regular ____Irregular ___Painful ___Heavy Every_____days Date of Last Pap: ______

Number of Pregnancies:____ Number of Births:____ Number of Miscarriages/Abortions:____ Infertility issues ?

Comments: Last menstrual period date(s):

Dates of Pregnancies / outcome:

Type of birth control: _____________________ How Long?_______ IUD? ____Yes ____No Years inserted _____________

Date of last mammogram _________________ History of breast disease?

Symptoms of menopause?

ADDITIONS TO HEALTH HISTORY