Patient History Form for Dr. Robert Rolf

Patient Name (print): ______________________________________ **Date of Birth:** ____________________
Gender: □ Male □ Female **Marital Status:** □ Single □ Married □ Divorced □ Widowed
Referred to Dr. Rolf □ Self □ Family □ Physician □ Attorney □ Other: _________________________

Name of Person(s) making referral: ____

PLEASE CHECK ANY OF THE FOLLOWING YOU ARE OR HAVE BEEN TREATED FOR:

□ AIDS/HIV	□ COPD	□ Depression	□ Hepatitis
□ Alcoholism	□ Colon Cancer	□ Diabetes	□ Kidney Disease
□ Alzheimer's	□ Lung Cancer	□ Drug Abuse	□ Osteoarthritis
□ Anemia	□ Breast Cancer	□ Gout	□ Seizures
□ Asthma	□ Prostate Cancer	□ Heart Disease	□ Ulcers
□ Blood Clots	□ Cancer (type) ____	□ Hypertension	□ Osteopenia or Osteoporosis

Please list any other medical conditions we should be aware of:

____
____
____
____

List any previous surgeries or overnight hospital stays (Please include year):

____
____
____
____

Who is your Medical Doctor?

____

What is your current height?____________________**What is your current weight?**____________________

Do you have any allergies to medication? □ Yes □ No **If yes, list medication(s) and reaction:**

____
____
____
____
____

PLEASE CHECK THE FOLLOWING CONDITIONS YOUR IMMEDIATE FAMILY (MOTHER, FATHER OR SIBLINGS) HAVE BEEN TREATED FOR:

□ AIDS/HIV	□ COPD	□ Depression	□ Hepatitis
□ Alcoholism	□ Colon Cancer	□ Diabetes	□ Kidney Disease
□ Alzheimer's	□ Lung Cancer	□ Drug Abuse	□ Osteoarthritis
□ Anemia	□ Breast Cancer	□ Gout	□ Seizures
□ Asthma	□ Prostate Cancer	□ Heart Disease	□ Ulcers
□ Blood Clots	□ Cancer (type) _____	□ Hypertension	□ Osteopenia or Osteoporosis

List any other conditions:____

Which hand do you write with? □ Right □ Left **Are you retired?** □Yes □ No

What is your occupation or job title? ____

Are you currently employed? □ Yes □ No

Who is your employer? ____

Circle the best description of your previous education (circle one):

Graduate School College graduate Some college HS Graduate GED Technical Training

Do you use tobacco? □ Yes □ No □ Former **If yes, which type?** Chewing Cigar Cigarettes Pipe

Please list amount and duration: (example 1 pack a day for 20 years)______________________

Do you consume alcohol? □ Yes □ No □ Former: **Do you consume caffeine ?** □ Yes □ No

Please list amount and duration: (example 2 sodas a day or alcohol socially)________________

How would you describe your activity level? (Circle one): Above average Average Sedentary

How frequently do you exercise? (Circle one)

2-3 times/week 3-4 times/week 5 times/week Daily Never Occasionally

Which physical activities or sports are you involved with?______________________________

Please list your hobbies or activities:____

____

PLEASE CHECK IF YOU <u>HAVE EVER HAD</u> ANY OF THE SYMPTOMS LISTED BELOW:

<u>Constitutional:</u>
□ Fever
□ Weight loss
□ Fatigue
□ Weakness
□ Dizziness

<u>Gastro-Intestinal:</u>
□ Ulcer
□ Frequent heartburn
□ Reflux
□ GI Bleeding

<u>Urinary:</u>
□ Prostrate problems
□ Kidney Stones
□ Chronic infections
□ frequent urination

<u>Cardiovascular:</u>
□ Chest Pain or angina
□ Shortness of breath
□ Heart murmur
□ Heart attack
□ Irregular heartbeat
□ Fainting or syncope
□ Ankle swelling
□ Rheumatic fever

<u>Surgical:</u>
□ Anesthesia problems
□ Wound healing problems

<u>Psychological:</u>
□ Depression
□ Anxiety disorder
□ Memory problems

<u>Respiratory:</u>
□ Asthma
□ COPD
□ Lung disease
□ Pneumonia
□ Tuberculosis

<u>Hematologic:</u>
□ Anemia
□ Poor Circulation
□ Phlebitis
□ Blood clots
□ Excessive bleeding
□ Blood transfusion

<u>Allergy/Immune:</u>
□ Seasonal Allergies
□ Skin conditions

<u>Musculoskeletal:</u>
□ Joint pain
□ Joint swelling
□ Muscle weakness
□ Muscle tenderness
□ Muscle spasms
□ Morning stiffness
□ Rheumatoid arthritis
□ Osteoporosis
□ Gout

<u>Neurological and ENT;</u>
□ Seizures or epilepsy
□ Stroke or TIA
□ Headaches
□ Trembling or Tremor
□ Balance problems
□ Hearing or vision loss

Please list any additional information which you think we might need to know to provide you with the best care possible:____

Patient signature:_________________________________ **Date:**____________________

Patient signature:_________________________________ **Date:**____________________