DR. SERENA
HEALTHCARE
WHOLE LIFE MEDICINE

13126 120th Ave NE, Kirkland WA 98034
(P) 425-398.9355 (F) 425-453-2827
www.DrSerena.com

MEDICAL HEALTH HISTORY FORM

Confidential Information

Name:_____ Birthdate: _____ Date:_____/_____/_____

GENERAL

Place of birth	Education
Relationship status	Occupation
Hobbies	Do you smoke? If yes how much
Exercise/recreation	Alcohol use
Weight Weight 1 year ago Maximum Weight	Height
Date of last Physical Exam	Date of last Eye exam
Date of last Colonoscopy	Date of last Prostate /Gyn exam
Date of last full Bloodwork	Date of last Bone Density testing
Date of last Mammogram	Date of last Dental Exam
Describe all serious accidents, severe injuries (include date occurred): ☐ None _____ _____ _____	List all serious illnesses, operations, hospitalizations (include date occurred) ☐ None _____ _____ _____

Primary Care Provider: _____ **Referring Provider:** _____

Self Referral: I found you online at (check box): □ Drserena.com □ Website Search □ Other_____

CURRENT MEDICAL CONDITIONS: Please list (in order of importance) your present health concerns

_____

_____

MEDICATIONS:	**Take For/How Much**		**Take For/How Much**
Hormone Therapy		Birth control	
Antibiotics/Antivirals		Thyroid medications	
Heart medications		Acne medications	
Mood medications		Osteoporosis medications	
Sleeping medications		Steroids	

Other medications not listed:_____

VITAMINS, MINERALS, HERBS:

ALLERGIES: NO KNOWN ALLERGIES check box ☐

Drug Allergies:			
Food Allergies:			
Environnemental Sources:			

CIRCLE IF YOU:

Diet often	Are under excessive stress	Are exposed to chemicals at work	Have thoughts of self harm
Have an eating disorder	Use recreational drugs, list:	Spiritual/religious affiliation None (circle) Or please indicate:	Desire weight loss

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DIET: *Please list typical foods consumed on a regular basis.*
Do you have any food restrictions? Y N (Circle) If yes please list: _____
Breakfast:_____
Lunch: _____
Dinner: _____
Snacks: _____
Fluids: _____
Alcohol: _____

PAST MEDICAL HISTORY

Measles	no	yes	Hives or Eczema	no	yes	chest x-ray	no	yes
Mumps	no	yes	Tuberculosis	no	yes	Infectious Mono	no	yes
Chickenpox	no	yes	Diabetes	no	yes	Rheumatic Fever	no	yes
Whooping Cough	no	yes	Cancer	no	yes	Mitral Valve Prolapse	no	yes
Scarlet Fever	no	yes	Polio	no	yes	Stroke	no	yes
Diptheria	no	yes	Glaucoma	no	yes	Hepatitis	no	yes
Smallpox	no	yes	Hernia	no	yes	Thyroid Disease	no	yes
Blood Transfusions	no	yes	Kidney Disease	no	yes	AIDs or HIV+	no	yes
Heart Disease	no	yes	Bleeding tendency	no	yes	Anemia	no	yes
Venereal Disease (STD's)	no	yes	Any other disease (please list)_____					

FAMILY HISTORY: (M = Mother, F = Father, MGM = Maternal Grandmother, PGM = Paternal Grandmother , PGF = Paternal Grandfather)

	Who & What Age		Who & What Age
Alcohol or Drug Problem		HIV	
Allergies		Kidney Disease	
Anemia		Leukemia	
Ankylosing Spondilitis		Mental Illness	
Asthma		Migraine Headaches	
Autoimmune disorders		Multiple Sclerosis	
Cancer		Early Menopause	
Chronic Lung Disease		Obesity	
Diabetes		Osteoporosis	
Eczema		Psoriasis	
Epilepsy		Parkinson's disease	
Glaucoma		Rheumatoid Arthritis	
Gout		Stroke	
Heart Disease		Thyroid Disease	
Hepatitis		Tuberculosis	
High Blood Pressure		Ulcers	
High Cholesterol		Other	

	Present age /or Age of death	If living, health (good, fair, poor)	If deceased, cause of death
Father:_____			
Mother: _____			
Siblings: _____			
Spouse: _____			
Children: _____			

Any other information you think is important:
_____