

Women Only

- | N/A | Past | Present | |
|-----------------------|-----------------------|-----------------------|--------------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Abnormal Pap Smear |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Abnormal Bleeding |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Lump in Breast |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Menstrual Cramps |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Hot Flashes |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Currently Pregnant |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | # of pregnancies _____ |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | PMS |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Menopause |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Female Orgasmic Disorder |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Other _____ |

Environmental

- | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Exposure to Toxins |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Exposure to Radiation |

Disease/Infection

- | | | | |
|-----------------------|-----------------------|-----------------------|---------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Parkinson's Disease |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Fibromyalgia |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Appendicitis |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Arthritis |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Asthma |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Bleeding Disorders |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Cancer |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Chemical Dependency |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Tic Disorder |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Diabetes |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Epilepsy |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Heart Disease |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | High Cholesterol |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Kidney Disease |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Liver Disease |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Migraines |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Multiple Sclerosis |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Stroke |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Thyroid Problems |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Ulcers |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Cerebral Palsy |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Seizure Disorder |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Other _____ |

Health Habits

- | N/A | Past | Present | |
|-----------------------|-----------------------|-----------------------|-----------------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Caffeine Type _____ |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Amount _____ |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Tobacco Type _____ |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Amount _____ |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Abuse of Prescription Drugs |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Nicotine Type _____ |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Alcohol Amount _____ |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Inhalants |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Other _____ |

List the medication you are currently taking to include dosage

List ALL allergies to environment, medication, animal, food, and substance

List medications you have taken in the past and if they worked for you or not

Date of Last Physical _____

Physician(s) _____

Current Medical Concerns

List all Surgeries, Accidents, or Trauma to include approximate date

Past medical conditions to include treating physician and outcomes

List ALL occasions when you experienced a concussion or traumatic brain injury

Who was the treating physician? _____

What was the outcome of the concussion or brain injury? Did you experience any behavior or mood changes?

List any occasion where you experienced trauma to the neck or back

Other health concerns or issues _____

Biological Family Medical History

Father	Living or Deceased	If deceased, state cause and age _____
	Present Health Problems _____	
	Hospitalizations _____	
Mother	Living or Deceased	If deceased, state cause and age _____
	Present Health Problems _____	
	Hospitalizations _____	
Maternal Grandfather	Living or Deceased	If deceased, state cause and age _____
	Present Health Problems _____	
	Hospitalizations _____	
Maternal Grandmother	Living or Deceased	If deceased, state cause and age _____
	Present Health Problems _____	
	Hospitalizations _____	
Paternal Grandfather	Living or Deceased	If deceased, state cause and age _____
	Present Health Problems _____	
	Hospitalizations _____	
Paternal Grandmother	Living or Deceased	If deceased, state cause and age _____
	Present Health Problems _____	
	Hospitalizations _____	
Siblings with Health Concerns _____		
Diagnosis _____		
Current Status _____		

Please note here any other biological relatives with significant health concerns/problems

Please understand: If it is reported to any PAS clinical or support staff that you have an infectious disease that your physician or care provider(s) does not know about, PAS is required by law to report it to our Local Health Department. Also, if it is reported that you have an infectious disease and are participating in activities that may unknowingly infect another person or persons, PAS is also required by law to report to local health department and law enforcement.

If you have a contagious illness/disease, please let us know so that we may provide a safe place for you to wait outside of the general waiting room area as not to infect other individuals.

THIS FORM IS PART OF THE COMPREHENSIVE DIAGNOSTIC ASSESSMENT USED TO GLEAN PERTINENT MEDICAL INFORMATION.