Penelope L. Shar, MD, LLC

543 A Hammond St
Bangor, Maine 04401
(207) 217-8878
www.optionsinhealing.com

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 ofen?_____

Length of sessions?_____

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

SLEEP: Hours / night?_____ Restless or restful? _____ 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.

____headaches
____neck lumps or swelling
____loss of balance
____dizzy spells
____vertigo
____blackouts or fainting
____blurry vision
____double vision
____cataracts
____eye pain or itching
____watery eyes or redness
____hearing difficulties
____noises or ringing in ears
____recurrent ear infections
____amalgam dental fillings
____dental problems/decay
____sore or bleeding gums
____sore tongue
____coated tongue
____loss of taste or smell
____sores in or around mouth
____difficulty swallowing
____cold sores or fever blisters
____sinus or nasal congestion
____runny nose
____frequent colds
____nasal polyps
____sore throats
____swollen glands
____recurrent fevers or chills
____hoarse voice
____shortness of breath
____wheezing
____coughing
____coughing up blood
____chest colds or pneumonia
____heart murmur

____high blood pressure
____skipped heartbeats
____racing heart
____chest pain or pressure
____swollen feet or ankles
____difficulty breathing at night
____varicose veins or phlebitis
____recurring indigestion
____nausea or vomiting
____intestinal gas/flatulence
____belching
____bloating
____abdominal pain or cramps
____constipation
____diarrhea or loose stools
____rectal itching
____blood with stools
____black stools
____pain in rectum
____jaundice
____hepatitis/pancreatitis
____colitis
____Crohn’s disease
____diverticulitis/diverticulosis
____frequent urination
____brown or red urine
____decreased force of urine
____frequent urge to urinate
____incontinence
____difficulty starting urination
____kidney or bladder infection
____venereal disease
____osteoporosis
____aching muscles or joints
____arthritis
____joint stiffness
____back or neck pain

____weakness
____painful feet
____leg cramps
____trembling or tremors
____seizures or epilepsy
____numbness or tingling
____skin tumors
____dry skin
____acne
____eczema
____skin rashes
____psoriasis
____dandruff or seborrhea
____hives
____itching or burning skin
____easy bruising
____hypothyroid (low)
____hyperthyroid (high)
____weight gain
____feel excessively warm
____feel excessively cold
____loss of appetite
____constant hunger
____fatigue
____night sweats
____diabetes
____low blood sugar
____nervousness or anxiety
____depression
____suicidal thoughts

--MEN ONLY--
____painful testicles
____hernia
____prostate problems
____sexual dysfunction

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
____eat at restaurants
____eat at fast food restaurants
____pastries, cookies, candies, ice cream, other sweets
____add sugar to coffee, tea, cereal, other foods
____colas, other soft drinks
____instant breakfasts, pop tarts, donuts, muffins
____cold breakfast cereals
____caffeine drinks (coffee, tea, cola, chocolate)
____deep fried food
____margarine of <u>any</u> type
____whole grain hot cereals
____meat (beef, veal, pork, ham, lamb, liver)
____chicken, turkey--circle: free-range, regular
____fresh fish--wild or farm raised
____processed luncheon meat
____fresh raw fruit
____fresh vegetables, raw or cooked
____salads
____whole grains or whole grain breads
____white bread or white flour products
____beans and legumes (lentil, kidney, chickpea, etc)
____yogurt--circle: whole, lowfat, plain or flavored
____milk--circle: whole, lowfat, skim
____cheese
____egg (circle): regular or free-range
____salt
____herbs, fresh and dried, spices
____water--circle: tap, filtered bottled
____artificial sweeteners
____eat if bored or depressed
____hurried or rushed meals
____stuff yourself
____swallow before chewing well
____sneak or hide foods
____read and understand food labels
____adequate fiber in diet
____shop at health food stores
____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							