

# Helen T. Gelhot, M.D.

## PATIENT HISTORY FORM



*This information will assist in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form. Patient information is HIPAA protected & used only for Smart Spa St Louis. It is never shared or sold.*

Patient's Name: \_\_\_\_\_  
Appointment Date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Marital status: Single:\_\_\_ Married:\_\_\_ Divorced:\_\_\_ Separated:\_\_\_ Widowed:\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: Home: (\_\_\_\_) \_\_\_\_\_ May we leave a message here? Y N  
Cell: (\_\_\_\_) \_\_\_\_\_ May we leave a message here? Y N  
E-mail: \_\_\_\_\_ May we send a message here? Y N

Your current (or previous) Primary Physician's name: \_\_\_\_\_  
Do you want your medical records sent to Dr. Gelhot from this physician? Y N

Date of last physical exam: \_\_\_\_\_ Date of any recent check-up: \_\_\_\_\_

Are you in good health at the present time to the best of your knowledge? Y N  
Explain a "No" answer: \_\_\_\_\_

Are you under a doctor's care at the present time? Y N  
If Yes, for what? \_\_\_\_\_

### **Problem(s) you are having today:**

#### **Allergies:** (medications, items, and foods):

Allergic Agent \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergic Agent \_\_\_\_\_ Reaction: \_\_\_\_\_

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Allergic Agent \_\_\_\_\_ Reaction: \_\_\_\_\_

#### **Current Medications / Supplements / Vitamins / Herbs:**

Hormone replacement therapy? (Men and women) Y N Type: of hormones \_\_\_\_\_

Birth control? Y N Type: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Freq: \_\_\_\_\_ Reason: \_\_\_\_\_

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**YOUR Medical Conditions:**

**Current and Past Conditions, Current or previous Treatments (Please circle)**

- |                          |   |  |
|--------------------------|---|--|
| Visual Problems/Glasses  | Rheumatic Fever                           | Osteoporosis                                 |
| Gallbladder/Liver        | Back Problems                             |  |
| Disease                  | Bleeding/Easy Bruising                    | Numbness/ Tingling<br>( <i>Extremities</i> ) |
| Neurological Problems    | Seizures                                  | Weight Gain/Loss                             |
| Headaches                | Asthma/Allergies                          |  |
|                          | Pelvic/Vaginal Infections                 | Daytime Sleepiness                           |
| Dizziness                | Breast Disease                            | Obesity                                      |
| Poor Focus/Concentration |   | Snoring                                      |
| Mood Swings              | Irritability                              | Fibromyalgia                                 |
| Achiness                 | Colds/Sore Throats<br>( <i>Frequent</i> ) | Chronic Fatigue Syndrome                     |
| Jaundice                 | Pneumonia                                 |  |
|                          | Bronchitis                                | Inability to Lose Weight                     |
| Psychological Problems   |   | Night Sweats                                 |
| Anemia                   | Skin Problems                             | Tobacco Use                                  |
| Cancer                   | Anxiety                                   | Vaginal Dryness                              |
| Anorexia/Bulimia         | Dry Skin                                  | Rosacea                                      |
| Hypertension             | Muscle Loss                               |  |
|                          | Less Exercise Tolerance                   | Acne   |
| Tuberculosis             |   | Swelling Feet                                |
| Drug/Alcohol Abuse       | Depression                                | Glaucoma                                     |
| Diabetes                 | Painful Intercourse                       | Constipation/Difficult BM                    |
| Blood Clots              | Irregular Menstruation                    | Polio  |
| Thyroid Problem/Goiter   | Overly Emotional                          |  |
|                          | Lack of Self Esteem                       | Lung Disease                                 |
| Heart Problems           |   | Cholera                                      |
| Stomach Problems/Ulcers  | Restless Leg Syndrome                     | Measles                                      |
| High Cholesterol         | Low Sex Drive                             | Mumps  |
| Gonorrhea/Herpes/Warts   | Memory Loss/Lapses                        | Scarlet Fever                                |
| Hair Loss                | Ear Infections                            |  |
|                          | Arthritis/Painful joints                  | Whooping Cough                               |
| Erectile Dysfunction     |   | Gout   |
| Muscle tone Loss         | Immune Problems                           | Malaria                                      |
| CVA/Stroke               | Poor Sleep                                | Tonsillitis                                  |
| Kidney Problems          | Palpitations                              | Pleurisy                                     |
| Syphilis/Chlamydia       | Fatigue/Tiredness                         |  |
|                          | Food Cravings                             | Chicken pox                                  |
| Hyperlipidemia           |   | Nervous breakdown                            |
| Urinary Tract Infections | Hot Flashes                               | Typhoid Fever                                |
| Hemorrhoids/Rectal       |   |  |

Other(s): \_\_\_\_\_

Notes / Details on circled items above: \_\_\_\_\_

**Surgeries / Hospitalization** (include dates): \_\_\_\_\_

Implants: ex: pacemaker, hip, knee, dental, etc Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, which type?  
\_\_\_\_\_ Date? \_\_\_\_\_

**Emergency Room / Urgent Care visits:** \_\_\_\_\_

**FAMILY HISTORY:** (circle any) include parents, grandparents, siblings, afflicted by:

- |                        |                        |
|------------------------|------------------------|
| Obesity                | Heart Disease          |
| Cancer                 | Blood Clot             |
| Breast Cancer          | Ovarian Cancer         |
| Kidney Disease         | High Blood Pressure    |
| Diabetes Adult (I)     | Asthma                 |
| Diabetes Juvenile (II) | Tuberculosis           |
| CVA/Stroke             | Arthritis              |
| Anemia                 | Thyroid/Goiter         |
| Epilepsy/Seizures      | Asthma/Allergies       |
| Birth Defects          | D.E.S. (mother)        |
| Liver Disease          | Mental Health Problems |
| Alzheimer's Disease    | Alcoholism             |
| Brain Aneurysm         | Glaucoma               |
| Asthma                 | Psychiatric Disorder   |

**Family morbidity/mortality specifics:**

**Mother:** illnesses \_\_\_\_\_ age \_\_\_\_\_

If deceased age of death \_\_\_\_\_ cause \_\_\_\_\_

**Father:** illnesses \_\_\_\_\_ age \_\_\_\_\_

If deceased age of death \_\_\_\_\_ cause \_\_\_\_\_

**Sibling I:** Sister or Brother: illnesses \_\_\_\_\_ age \_\_\_\_\_

If deceased age of death \_\_\_\_\_ cause \_\_\_\_\_

**Sibling II:** Sister or Brother: illnesses \_\_\_\_\_ age \_\_\_\_\_

If deceased age of death \_\_\_\_\_ cause \_\_\_\_\_

**Sibling III:** Sister or Brother: illnesses \_\_\_\_\_ age \_\_\_\_\_

If deceased age of death \_\_\_\_\_ cause \_\_\_\_\_

**Sibling IV:** Sister or Brother: illnesses \_\_\_\_\_ age \_\_\_\_\_

If deceased age of death \_\_\_\_\_ cause \_\_\_\_\_

**Additional Significant Family Information:** aunts/uncles (related by blood) or cousins:

\_\_\_\_\_  
\_\_\_\_\_

**YOUR LIFESTYLE HISTORY**

**Tobacco use:** Y N

Type: \_\_\_\_\_ Number of events/day \_\_\_\_\_

Number of years smoked/use? \_\_\_\_\_ If quit how long ago? \_\_\_\_\_

**Alcohol use:** Y N

Type: \_\_\_\_\_

Number of drinks per occasion: 1 2 3 4 5 6 7 8

Number of occasions per week month year: 1 2 3 4 5 6 7 8

Number of years alcohol used? \_\_\_\_\_ If quit how long ago? \_\_\_\_\_

**Behavior style (check one):**

\_\_\_\_\_ You are **always calm** and easygoing.

\_\_\_\_\_ You are **usually calm** and easygoing.

\_\_\_\_\_ You are **sometimes calm** with frequent impatience.

\_\_\_\_\_ You are seldom calm and **persistently driving for advancement.**

\_\_\_\_\_ You are never calm and have **overwhelming ambition.**

\_\_\_\_\_ You are hard-driving and can **never relax.**

***I am interested in making changes or need counseling in:*** (Circle areas of interest):

- 1. Smoking cessation
- 2. Weight control
- 3. Decrease alcohol consumption
- 4. Exercise
- 5. Decrease use of non prescription drugs
- 6. Nutrition
- 7. Stress management

**Describe your general health goals and improvements you wish to make:**

\_\_\_\_\_  
\_\_\_\_\_

**LEISURE**

What do you do you like to do for FUN? \_\_\_\_\_

How often do you do it? \_\_\_\_\_

Other RELAXATION activities \_\_\_\_\_

How often do you do those ? \_\_\_\_\_

**Physical Activity / Exercise:**

Activity type: \_\_\_\_\_ Period (i.e. 30 min) \_\_\_\_\_ # per Week \_\_\_\_\_

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Notes: \_\_\_\_\_

**Body Mass Index (BMI) Information:**

Your Height \_\_\_\_\_ Your Weight: \_\_\_\_\_ (do you know) Current BMI: \_\_\_\_\_

Are you presently dieting? Y N

If so which diet? \_\_\_\_\_

Have you previously dieted to lose weight? Y N

Dates/Age \_\_\_\_\_ Diet type? \_\_\_\_\_

Amount of weight loss? \_\_\_\_\_ Amount of weight regained? \_\_\_\_\_

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Notes: \_\_\_\_\_

Your Birth Weight: \_\_\_\_\_ Weight at 20 years old : \_\_\_\_\_ Weight one year ago: \_\_\_\_\_

Lowest Adult weight ever: \_\_\_\_\_ Age: \_\_\_\_\_

Highest weight ever: \_\_\_\_\_ Age: \_\_\_\_\_

Desired weight Now: \_\_\_\_\_ Within what time frame? \_\_\_\_\_

Your main reason to lose weight now: \_\_\_\_\_

When did you begin gaining excess weight? (Give reasons, if known): \_\_\_\_\_

What has been your maximum lifetime weight (non-pregnant) and when? \_\_\_\_\_

Is your spouse, fiancée or partner overweight? Y N If so, by how much? \_\_\_\_\_

**Nutrition:**

Non-homemade or brown-bag meals/week (breakfast, lunch, dinner), consider *drive thru or eat in, office or home, take out or delivery*. \_\_\_\_\_ Notes: \_\_\_\_\_

What restaurants do you frequent? \_\_\_\_\_

Who plans family meals? \_\_\_\_\_ Cooks? \_\_\_\_\_ Shops? \_\_\_\_\_

Do you use a shopping list? Y N Notes: \_\_\_\_\_

What day & time do you usually shop for groceries? \_\_\_\_\_

Do you count daily caloric intake: Y N Estimated Calories/Day \_\_\_\_\_

Food dislikes: \_\_\_\_\_

Food(s) you crave: \_\_\_\_\_

Any specific time of the day or month do you crave food? \_\_\_\_\_

Caffeinated Coffee / Tea / Drinks? Y N  
How much daily caffeine (oz)? \_\_\_\_\_ How much after 6PM (oz)? \_\_\_\_\_

Do you use a sugar substitute? Y N Butter? Y N Margarine? Y N

Notes: (Brand Names) \_\_\_\_\_

Do you awaken hungry during the night? Y N Frequency? \_\_\_\_\_

What do you do about it? \_\_\_\_\_

What are your worst food habits? \_\_\_\_\_

Snack Habits: What? \_\_\_\_\_

How much? \_\_\_\_\_ When? \_\_\_\_\_

When you are under a stressful situation at work or home, do you tend to eat more?  
Y N Explain: \_\_\_\_\_

Do you think you are currently undergoing a stressful situation or an emotional upset?  
Explain: \_\_\_\_\_

Typical breakfast \_\_\_\_\_

Time eaten \_\_\_\_\_ Where \_\_\_\_\_ With whom \_\_\_\_\_

Typical lunch \_\_\_\_\_

Time eaten \_\_\_\_\_ Where \_\_\_\_\_ With whom \_\_\_\_\_

Typical dinner \_\_\_\_\_

Time eaten \_\_\_\_\_ Where \_\_\_\_\_ With whom \_\_\_\_\_

**INFECTIOUS DISEASE**

**Recent Travel (in the past year):**

Place: \_\_\_\_\_ Date: \_\_\_\_\_

Place: \_\_\_\_\_ Date: \_\_\_\_\_

Place: \_\_\_\_\_ Date: \_\_\_\_\_

Place: \_\_\_\_\_ Date: \_\_\_\_\_

**Immunizations/ Infectious disease:**

Have you ever been hospitalized? Yes No If yes, what for? \_\_\_\_\_

Have you ever been tested for hepatitis A, B or C? Yes No

Which hepatitis virus? \_\_\_\_\_ Positive for: \_\_\_\_\_

Have you been vaccinated for hepatitis B? Yes No

If yes, date vaccine series completed \_\_\_\_\_

Have you been vaccinated for hepatitis A? Yes No

If yes, date vaccine series completed \_\_\_\_\_

Have you been vaccinated for Influenza? Y N Date \_\_\_\_\_

Td (tetanus)? Y N Date \_\_\_\_\_

Tdap (tetanus, diphtheria and pertussis)? Y N Date \_\_\_\_\_  
OPV (polio) Y N Date \_\_\_\_\_  
MMR (measles, mumps, rubella) Y N Date \_\_\_\_\_  
Varicella Y N Date \_\_\_\_\_  
Other \_\_\_\_\_ Y N Date \_\_\_\_\_  
Have you been tested for HIV? Y N  
If so were you: positive negative

**TB:**

When was your last Tuberculosis (TB) Screening? \_\_\_\_\_  
Result of TB screening: Positive Negative  
If positive TB screen, date of last chest x-ray: \_\_\_\_\_  
Result of chest x-ray: Positive Negative

**STDs:**

Have you had a sexually transmitted disease? Yes No  
If yes: Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_

**OCCUPATIONAL HISTORY:** Present job:

What type of work do you do? \_\_\_\_\_  
How long have you had this job? \_\_\_\_\_  
Are you exposed to any of the following on your present job?  
Chemicals \_\_\_\_\_ Vapors/Gases \_\_\_\_\_ Dusts \_\_\_\_\_  
Metals \_\_\_\_\_ Extreme heat or cold \_\_\_\_\_ Loud noise \_\_\_\_\_  
Vibration \_\_\_\_\_ Radiation \_\_\_\_\_ Infectious agents \_\_\_\_\_  
Stress \_\_\_\_\_

Do you feel you have any health problems related to your work? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_

List any injuries or illnesses during previous work years, include dates: \_\_\_\_\_  
\_\_\_\_\_

Any hobbies that expose you to chemicals, metals, or other substances? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please describe: \_\_\_\_\_

Do you live near any sources of pollution? (Dump sites, etc.) Y N  
If yes, please explain: \_\_\_\_\_

Additional information: \_\_\_\_\_  
\_\_\_\_\_

**COSMETIC:**

Have you ever had Botox injections? Y N  
If yes, have you had any reaction(s)? Y N  
If yes, please describe \_\_\_\_\_  
Have you ever had any filler injections? Y N  
If yes, which fillers? \_\_\_\_\_  
Have you had any reaction(s)? Y N  
If yes, please describe \_\_\_\_\_

**~~ALL MALES STOP HERE; Please Proceed to Signature Page~~**

**GYNECOLOGICAL HISTORY (FEMALES):**

Last normal menstrual period: \_\_\_\_\_ Or age at Cessation of menses? \_\_\_\_\_

Age of onset of menstruation: \_\_\_\_\_

Cycles: Regular \_\_\_\_\_ Irregular \_\_\_\_\_

Duration: # of days \_\_\_\_\_

Scant \_\_\_\_\_ Moderate \_\_\_\_\_ Heavy \_\_\_\_\_

Do you have Bleeding between periods now? Y N In the past? Y N

Premenstrual syndrome \_\_\_\_\_

Ovarian cysts? Y N Multiple Ovarian Cysts? Y N

Uterine fibroid(s)? \_\_\_\_\_

Last pap smear/result: \_\_\_\_\_

Have you ever had an abnormal pap test? Y N Treatment of cervix? Y N

Have you had a hysterectomy? Y N

Last mammogram date? \_\_\_\_\_ Breast Biopsy? Y N

Last physician breast exam? \_\_\_\_\_

Do you perform regular self-breast exams? Y N

Do you have sexual problems? Y N

Do you have problem vaginal discharge/itching now? Y N

Have you had problem vaginal discharge/itching previously? Y N

Do you Douche? Y N Type? \_\_\_\_\_ How often? \_\_\_\_\_

Present birth control method (type and number of years used): \_\_\_\_\_

Previous methods: \_\_\_\_\_

Additional information: \_\_\_\_\_

**OBSTETRICAL HISTORY (FEMALES):**

Number of pregnancies \_\_\_\_\_ Number of deliveries \_\_\_\_\_

Abortions (miscarriages or elective) \_\_\_\_\_ Vaginal deliveries \_\_\_\_\_

Caesarean section \_\_\_\_\_ Date of last delivery \_\_\_\_\_

Complications during pregnancy? Y N

If so problems were related to: Blood pressure Y N Blood sugar Y N

Weight gain Y N Anemia Y N If Other, explain \_\_\_\_\_

Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE:**

*By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.*

\_\_\_\_\_  
**Patient/Legal Guardian Signature**

\_\_\_\_\_  
**Date**

Again, thank you for your time and patience in completing this form.

**In consideration of valuable time, return a copy of this history to our office prior to your appointment.**

**Please bring the original to your first visit with the doctor.**

REV: 1 Aug., 2011 pk/ht