DR JOHN P SALERNO

SALERNO WELLNESS

CONFIDENTIAL HEALTH FORM

PREFERRED OFFICE LOCATION

☐ NY ☐ CT

Thank you for choosing The Salerno Center. The following is an integral part in our collaborative journey to better health and wellness. Please take the time to carefully complete each section. The last page is left blank for any relevant additional information you would like to provide to your physician.

PATIENT DETAILS:

FULL NAME

NICK NAME

DOB

AGE

BLOOD TYPE

SEX ☐ MALE ☐ FEMALE

MARITAL STATUS

SEXUAL ORIENTATION

NATIONALITY

OCCUPATION

PRIMARY CONCERNS:

Please use the following to best describe the primary reason you are seeking medical care today.

CONCERN	SYMPTOMS	ONSET/DURATION

SYMPTOMS: Please use the following to best describe your primary issues and when they began or how long they have been a concern.

HEALTH ISSUE	SYMPTOMS	ONSET/DURATION

MEDICATION & SUPPLEMENTS:

MEDICATION & SUPPLEMENTS: Please list all medications and supplements that you take on a regular basis.

MEDICATION/SUPPLEMENT	PURPOSE	DOSE	FREQUENCY	RESPONSE

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ALLERGIES:

Please list any allergies to supplements, medications, foods, or environmental substances.

ALLERGY	REACTION

MEDICAL HISTORY:

Please detail any hospitalizations and/or surgeries you have had:

REASON FOR HOSPITALIZATION AND/OR SURGERY	OUTCOME	DATE

Please list any major illnesses that you have had in the past:

ILLNESS	DATE OF ONSET	DATE OF RESOLUTION

Are you presently under the care of a physician, chiropractor, naturopath, acupuncturist, or other health practitioner? ☐ YES ☐ NO

PRACTITIONER	SPECIALTY	LOCATION	TELEPHONE

WOMEN

AGE OF MENSTRUAL ONSET	LAST MENSTRUAL PERIOD	DAYS BETWEEN PERIODS	DURATION OF PERIOD

NUMBER OF PREGNANCIES/CHILDREN

ARE YOUR PERIODS REGULAR? ☐ YES ☐ NO

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HEALTH MAINTENANCE :

Please list the date of the most recent of the following, and bring whatever results you may have with you to your appointment.

ITEM	DATE	ITEM	DATE	ITEM	DATE
COMPLETE PHYSICAL		VISION TEST		**WOMEN**	
EKG		TETANUS BOOSTER		PAP SMEAR	
CARDIAC STRESS TEST		HEPATITIS B VACCINE		MAMMOGRAM	
MRI/CT		BONE DENSITY		BREAST EXAM	
X-RAYS					
DENTAL		**MEN**		**CHILDREN**	
CHOLESTEROL TEST		PROSTATIC EXAM		IMMUNIZATIONS	
STOOL BLOOD TEST		PSA BLOOD TEST			

DIETARY HABITS:

Please list a record of what you would normally eat and drink in a given day, indicate if you often skip a meal

BREAKFAST

FOOD	BEVERAGES

LUNCH

FOOD	BEVERAGES

DINNER

FOOD	BEVERAGES

SNACKS & SWEETS

FOOD	BEVERAGES

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How many times per day/week do you eat the following foods?

ITEM	NUMBER	ITEM	NUMBER	ITEM	NUMBER	ITEM	NUMBER
BEEF		CHICKEN		FISH		PORK	
EGGS		CHEESE		FRUIT		VEGETABLES	
SALAD		SUGAR		OTHER			

WHAT DO YOU DRINK IN BETWEEN MEALS?

WHAT IS YOUR CURRENT WEIGHT? | HOW TALL ARE YOU? | WHAT IS YOUR IDEAL WEIGHT? | ARE YOU TRYING TO LOSE WEIGHT? ☐ YES ☐ NO

WHAT IS THE MOST YOU HAVE EVER WEIGHED? | WHAT IS THE LEAST YOU HAVE EVER WEIGHED? | ARE YOU TRYING TO GAIN WEIGHT? ☐ YES ☐ NO

HAVE YOU DIETED IN THE PAST?

☐ YES ☐ NO

PERSONAL HABITS

TOBACCO

DO YOU CURRENTLY OR HAVE YOU EVER SMOKED? ☐ YES ☐ NO

IF YES, WHAT? | HOW MUCH? | HOW LONG? | WHEN DID YOU QUIT?

ALCOHOL

DO YOU CURRENTLY DRINK ALCOHOL? ☐ YES ☐ NO — IF YES, WHAT KIND AND HOW OFTEN?

HAVE YOU EVER HAD A DRINKING PROBLEM? ☐ YES ☐ NO — IF YES, HOW LONG SOBER?

DO YOU STILL REGULARLY ATTEND MEETINGS? ☐ YES ☐ NO — WHAT KIND OF MEETING?

RECREATIONAL DRUGS

DO YOU USE RECREATIONAL DRUGS? ☐ YES ☐ NO — IF YES, WHICH ONES?

HAVE YOU EVER USED INTRAVENOUS DRUGS? ☐ YES ☐ NO — IF YES, WHEN WAS THE LAST TIME?

HAVE YOU EVER BEEN TREATED FOR A DRUG PROBLEM? ☐ YES ☐ NO — ARE YOU STILL IN TREATMENT? ☐ YES ☐ NO

EXERCISE

DO YOU CURRENTLY EXERCISE? ☐ YES ☐ NO

TYPE OF EXERCISE	FREQUENCY	DURATION

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MISCELLANEOUS

DO YOU DRINK COFFEE? ☐ YES ☐ NO HOW MANY 8 OZ CUPS PER DAY? ☐

DO YOU TAKE LAXATIVES ☐ YES ☐ NO WHAT KINDS? ☐ HOW OFTEN? ☐

DO YOU TAKE ANTACIDS? ☐ YES ☐ NO WHAT KINDS? ☐ HOW OFTEN? ☐

HOW MANY HOURS OF SLEEP DO YOU GET EACH NIGHT? ☐ DO YOU FEEL RESTED IN THE AM? ☐ YES ☐ NO

DO YOU HAVE PROBLEMS FALLING OR STAYING ASLEEP ☐ YES ☐ NO DO YOU HAVE NIGHT SWEATS? ☐ YES ☐ NO

DO YOU WAKE FREQUENTLY? ☐ YES ☐ NO WHAT TIME? ☐

ARE YOU SEXUALLY ACTIVE? ☐ YES ☐ NO

DO YOU USE CONDOMS DURING SEXUAL INTERCOURSE? ☐ YES ☐ NO

CHILDREN ONLY

	AT SCHOOL?	AT HOME?	AT PLAY?
DOES YOUR CHILD RELATE WELL TO OTHERS?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
HAVE YOU EVER BEEN TOLD YOUR CHILD HAS AN ATTENTION PROBLEM?	☐ YES ☐ NO	WAS S/HE EVALUATED?	☐ YES ☐ NO
DOES YOUR CHILD HAVE EARACHES?	☐ YES ☐ NO	HOW MANY? ☐	HOW OFTEN? ☐

HOW MANY TIMES HAS YOUR CHILD BEEN ON ANTIBIOTICS? ☐

PSYCHOLOGICAL/SPIRITUAL ASSESSMENT

		AT HOME?	AT WORK?
DO YOU CONSIDER YOURSELF UNDER STRESS?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
HOW MUCH DOES THIS STRESS INTERFERE WITH YOUR LIFE?	☐ ALWAYS ☐ MOST OF THE TIME ☐ OCCASIONALLY ☐ NOT AT ALL		
ARE YOU CURRENTLY IN A RELATIONSHIP WITH SOMEONE?	☐ YES ☐ NO		
HOW SATISFIED ARE YOU WITH THE RELATIONSHIP?	☐ VERY SATISFIED ☐ MOSTLY SATISFIED ☐ SOMEWHAT SATISFIED ☐ NOT AT ALL		
DO YOU FREQUENTLY BECOME DEPRESSED?	☐ YES ☐ NO		
HAVE YOU EVER BEEN TREATED FOR DEPRESSION?	☐ YES ☐ NO		
DO YOU HAVE MOOD SWINGS?	☐ YES ☐ NO		
DO YOU CONSIDER YOURSELF COMPULSIVE?	☐ YES ☐ NO		
DO YOU CONSIDER YOURSELF IMPULSIVE?	☐ YES ☐ NO		
ARE YOU ANXIOUS?	☐ YES ☐ NO		
DO YOU GET RILED EASILY?	☐ YES ☐ NO		
DO YOU HAVE A RELIGIOUS OR SPIRITUAL PRACTICE?	☐ YES ☐ NO	IF YES, WHAT? ☐	

FAMILY HISTORY:

Please list ages, health problems and cause of death if deceased below:

FAMILY MEMBER	LIVING (AGE)	HEALTH ISSUE(S)	DECEASED (AGE)	CAUSE
MOTHER				
FATHER				
BROTHER(S)				
SISTER(S)				
MATERNAL GRANDMOTHER				
MATERNAL GRANDFATHER				
PATERNAL GRANDMOTHER				
PATERNAL GRANDFATHER				

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REVIEW OF BODY SYSTEMS:

Do you have a present or past history of any of the following? Please check all that apply.

AREA	PRESENT	PAST	SYMPTOMS
NEUROLOGICAL			
	☐	☐	Recurrent Headaches
	☐	☐	Migraines
	☐	☐	Dizziness
	☐	☐	Speech Difficulties
	☐	☐	Visual Disturbances
	☐	☐	Muscle Weakness
	☐	☐	Memory Loss
	☐	☐	Seizures
EAR/NOSE/THROAT			
	☐	☐	Wear Glasses or Contacts
	☐	☐	Double Vision
	☐	☐	Cataracts
	☐	☐	Hearing Loss
	☐	☐	Ringing in Ears
	☐	☐	Ear Infections
	☐	☐	Sinus Problems
	☐	☐	Frequent Sore Throats
	☐	☐	Hoarseness
	☐	☐	Difficulty Swallowing
	☐	☐	Decreased Ability to Smell
CARDIOVASCULAR			
	☐	☐	Chest Pain
	☐	☐	Palpitations
	☐	☐	Heart Attack
	☐	☐	Murmurs
	☐	☐	Rheumatic Fever
	☐	☐	High Blood Pressure
	☐	☐	Atrial Fibrillation
	☐	☐	Fainting
	☐	☐	Angle Swelling
	☐	☐	Leg Pain While Walking
RESPIRATORY			
	☐	☐	Shortness of Breath
	☐	☐	Wheezing
	☐	☐	Chronic Cough
	☐	☐	Blood in Sputum
	☐	☐	Bronchitis
	☐	☐	Emphysema
	☐	☐	Pneumonia
	☐	☐	Asthma
GENITO-URINARY:			
	☐	☐	Frequent Urination
	☐	☐	Blood in Urine
	☐	☐	Nighttime Urination
	☐	☐	Pain on Urination
	☐	☐	Kidney Infections
	☐	☐	Kidney Stones
	☐	☐	Prostate Infections
	☐	☐	Enlarged Prostate
	☐	☐	Painful Intercourse

AREA	PRESENT	PAST	SYMPTOMS
GASTRO-INESTINAL			
	☐	☐	Nausea
	☐	☐	Vomiting
	☐	☐	Abdominal Pains
	☐	☐	Heartburn
	☐	☐	Recurring Diarrhea
	☐	☐	Frequent Constipation
	☐	☐	Changes in Bowel Habit
	☐	☐	Blood in Stools
	☐	☐	Gallstones
	☐	☐	Ulcers
	☐	☐	Hepatitis
GYNECOLOGICAL			
	☐	☐	PMS
	☐	☐	Irregular Periods
	☐	☐	Infertility
	☐	☐	Gestational Diabetes
	☐	☐	Menopause
SKIN			
	☐	☐	Skin Growths
	☐	☐	Change in Color of Growth
	☐	☐	Skin Cancer
	☐	☐	Hives
	☐	☐	Rashes
	☐	☐	Eczema
	☐	☐	Psoriasis
	☐	☐	Athlete's Foot
	☐	☐	Hair Loss
	☐	☐	Nail Fungus
	☐	☐	Canker Sores
MISCELLANEOUS			
	☐	☐	Diabetes
	☐	☐	Thyroid Problems
	☐	☐	STD
	☐	☐	Herpes
	☐	☐	Anemia
	☐	☐	Allergies
	☐	☐	Cancer
	☐	☐	Where?
	☐	☐	Chronic Infections
	☐	☐	Where?

ADDITIONAL INFORMATION:

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