LEIGH BAKER, D.O. 5 Fundy Road, Falmouth, Maine 04105 207.846.7666

FORMS Fill out prior to your appointment and bring with you. Call the office with any questions.

DATA BASE SHEET : SIDE 1

Todays Date: ______________________
Month / Day / Year

Name___________________________
Occupation______________________
Hobbies_________________________

What problem brought you here today? ____

Who is your primary care doctor? ________________________________

When was the last time you were in the hospital? ____________________________

IN THE LAST YEAR HAVE YOU HAD (check YES or NO)

YES	NO	(1)	YES	NO	(2)	YES	NO	(3)
___	___	dizziness	___	___	eye pain	___	___	many earaches
___	___	fainting spells	___	___	vision problems	___	___	ringing in ears
___	___	headaches	___	___	blurred vision	___	___	ear discharge
___	___	convulsion/"fit"	___	___	light bother eyes	___	___	deafness
		(4)			(5)			(6)
___	___	nosebleeds	___	___	chest pain	___	___	coughing spells
___	___	sinus/hay fever	___	___	short of breath	___	___	asthma or emphysema
___	___	nasal discharge	___	___	heart palpitation	___	___	cough up blood
___	___	sore throats	___	___	swollen ankles	___	___	TB or pneumonia
___	___	trouble w/swallow	___	___	night sweating	___	___	many colds
___	___	much hoarseness	___	___	numb hand/foot	___	___	pain w/breathing
		(7)			(8)	___	___	breast tender/sore
___	___	stomach pain/cramps	___	___	urgent need to void	___	___	new breast lumps
___	___	much gas after eating	___	___	smoky colored urine	___	___	nipple discharge
___	___	foods you can't eat	___	___	leaking of urine			(9)
___	___	diarrhea/constipation	___	___	pain/burn w/urination	___	___	depression
___	___	nausea or vomiting	___	___	kidney/bladder infect.	___	___	nervousness
___	___	rectal pain/bleeding	___	___	dribbling after urination	___	___	insomnia
___	___	blood in stools	___	___	difficult start/stop stream	___	___	hands shake
___	___	white or black stools	___	___	urine stream split/spray	___	___	skin itches
___	___	change in bowel habits	___	___	frequent urination			
		(bowels move ___ times/day) ___times/week			(daily or nightly)			
		(10)			(11)			
___	___	muscle ache	___	___	marked tiredness			
___	___	muscle cramps	___	___	recent weigh change			
___	___	joint pain/arthritis	___	___	frequent thirst			
___	___	joint stiffness	___	___	increased appetite			
___	___	hot or cold hands/feet	___	___	poor appetite			

___ ___ Do you use laxatives? How often? _______________

___ ___ Do you use alcohol? How often? _______________ How much? _______________ Number of years ____

___ ___ Do you use tobacco? How often? _______________ Packs per day _________ Number of years_____

How much sleep do you get each night? ____ hours. Do you wake up at night? ___________________________

How much do you drink of: water___ milk ___ coffee ___ tea ___ other ______________________________

HAVE YOU HAD ANY *SURGERY* ON ANY OF THE FOLLOWING:

Yes	No	Year		Yes	No	Year		Yes	No	Year	
___	___	___	legs or arms	___	___	___	chest	___	___	___	back
___	___	___	prostate	___	___	___	breast	___	___	___	neck
___	___	___	appendix	___	___	___	spine				
___	___	___	gallbladder	___	___	___	female organs				
___	___	___	tonsils	___	___	___	cesarean section				
___	___	___	tumor (anywhere)	___	___	___	hemorrhoids (piles)				
___	___	___	hernia (rupture)	___	___	___	other surgeries (list)				

Have you ever had broken or dislocated bones or bad cuts? ____

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What medications are you currently taking? (list)

____

____

Vitamin or mineral supplements? (list) ______________________________

____

Do you experience reactions to any DRUGS? (list)

____

PAST ILLNESSESS

Yes	No	Year		Yes	No	Year	
___	___	___	measles	___	___	___	migraine headache
___	___	___	mumps	___	___	___	heart problems
___	___	___	chickenpox	___	___	___	kidney problems
___	___	___	German measles	___	___	___	epilepsy or convulsion
___	___	___	polio	___	___	___	blood or bleeding problems
___	___	___	rheumatic fever	___	___	___	venereal disease (V.D. or G.C)
___	___	___	scarlet fever	___	___	___	diabetes (sugar)
___	___	___	tuberculosis	___	___	___	thyroid disease
___	___	___	pneumonia	___	___	___	blood transfusions or jaundice
___	___	___	whooping cough	___	___	___	high blood pressure
___	___	___	ALLERGIES	___	___	___	varicose veins

EXERCISE:	How often (per day/week)	Minutes
________	________	____
________	________	____
________	________	____

FAMILY HISTORY

	Living?	Age	State of health	Deceased	Age	Cause of Death
Father	____	____	________	____	____	________
Mother	____	____	________	____	____	________

Number of sisters ______ brothers ______ Illnesses? (who) ______________

Have your grandparents, parents, uncles, aunts, brothers, sisters or children ever been treated for any of the following:

Yes	No		Who?	Yes	No		Who?
___	___	Cancer (type) _______	________	___	___	Hardening of arteries	________
___	___	Diabetes	________	___	___	Kidney trouble	________
___	___	Tuberculosis	________	___	___	High blood pressure	________
___	___	Heart disease	________	___	___	Hay fever or asthma	________
___	___	Nervous breakdown	________	___	___	Mental illness/problems	________