Date: _____

Dr. Streeter's Health History Form

Name: _____, _____ DOB: _____ Ph: _____
(Last) (First) (MI)

Address: _____ City: _____ St: _____ Zip: _____

E-Mail: _____ Ht: _____ Wt: _____

Surgical History & Dates of Each: _____

_____

Serious Prior Medical Conditions: _____

_____

Medications (names, amounts, reason for each: _____

_____

_____

REVIEW OF SYSTEMS (please list or circle health issues)

GASTROINTESTINAL: constipation, diarrhea, nausea, vomiting, gastric upset, indigestion, other.

GENITAL URINARY: urinary tract infections, bladder or kidney problems, burning or blood with urination, urine incontinence or other urinary issues.

MEN: prostate issues, frequent urination at night, erectile dysfunction, or other issues.

WOMEN: menstrual problems, ovulation issues, PMS, pregnancies, menopausal symptoms, or other.

CARDIOVASCULAR: tightness in chest, shortness of breath, racing or irregular heart beat, high blood pressure, swelling in ankles (edema), cold hands/feet, other.

NEUROLOGICAL: headaches, dizziness, blurred or double vision, black outs, seizures, numbness in fingers or toes, other.

RESPIRATORY: coughs, colds, infections, smoker, shortness of breath, asthma, other lung conditions.

MUSCULO-SKELETAL: muscle weakness, joint pain, cramps/charley horses, joint swelling, other.

SKIN: rashes, boils, bumps, warts, other.

Specify any 'Other' answers: _____

Please contact either: Charisse: E-Mail hes1220@gmail.com Phone: 574-529-1980

or Cal: streetercal1@gmail.com 269-267-8231