

CATHERINE ARVANTELY, M.D., P.C. & INDEPENDENT ASSOCIATES  
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NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

### PATIENT INFORMATION FORM

Home Address \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Email Address \_\_\_\_\_ Fax \_\_\_\_\_  
(If you have email access, please complete. We will not share your email address.)

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employment Address \_\_\_\_\_

Nearest Relative/Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Primary Physician \_\_\_\_\_ Phone \_\_\_\_\_

How Did You Find Us? \_\_\_\_\_

Name of Medical Insurance Carrier \_\_\_\_\_

If Patient is Under 18 Years Old, Name of Parent/Guardian \_\_\_\_\_

Do we have your permission to leave a message on your phone voicemail regarding personal medical information? YES / NO (circle one)

If YES, at which phone number may we leave a personal message?  
HOME / WORK / CELL (circle one, two or all)

\_\_\_\_\_  
M.D. INITIALS

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

### HEALTH HISTORY PACKET

Dear Patient,

Thank you for taking the time to complete your Health History Packet prior to your first appointment. Please remember to write your name and the date on each page. We look forward to working with you! Warmly, Dr. Arvantely, Dr. Chang and Staff

### REASON FOR VISIT

**PRIMARY COMPLAINT(S):**

Please tell us about the main health complaint(s) that have brought you to the office today. You may simply list symptoms or briefly explain what's bothering you.

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**PREVIOUS TREATMENTS:**

Please briefly describe or list what you've tried or taken so far to help alleviate your problem(s).

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**ADDITIONAL SYMPTOMS:**

Please feel free to list or elaborate on any additional symptoms that may or may not be related to your primary complaint (but that you feel are important). Please remember that no symptom or complaint is ever considered trivial.

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NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**MEDICATIONS**

Please list the medication(s) you are currently taking. You may list on a separate page.

Name of Medication	Dosage	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____
7. _____	_____	_____
9. _____	_____	_____
10. _____	_____	_____

**SUPPLEMENTS**

What vitamins, minerals, herbal supplements, enzymes or probiotics do you take? You may bring your supplements to your first visit.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**DRUG ALLERGIES**

To what drugs are you allergic?

What type of reactions do they cause?

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**FOOD ALLERGIES**

To what foods are you allergic?

What type of reactions do they cause?

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**PERSONAL AND FAMILY MEDICAL HISTORY**  
**Please place a CHECK in the box for all disorders present.**

	SELF	Mother's Mother	Mother's Mother	Mother's Father	Father's Father	Father's Mother	Father's Father	Aunts	Uncles	Siblings
Living (Age)										
Deceased (Age)										
Alcoholism										
Alzheimers										
Anemia										
Arthritis										
Asthma										
Bleeding Tendency										
Bone Fractures										
Cancer										
Breast Cancer										
Ovary Cancer										
Uterus Cancer										
Cervix Cancer										
Lung Cancer										
Colon Cancer										
Prostate Cancer										
Skin Cancer										
Crohn's Disease										
Chronic Fatigue Synd										
Clots in Veins										
Colon Polyps										
Diabetes										
Diverticulosis										
Endometriosis										
Fibromyalgia										
Glaucoma										
Gall Bladder Dis.										
Heart Murmur										
Heart Problems										
Hepatitis										
High Cholesterol										
High Blood Pressure										
HIV										
Irritable Bowel Synd										
Kidney Dis./ Stones										
Liver Disease										
Lung Disease										

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**PERSONAL AND FAMILY MEDICAL HISTORY – continued**  
**Please place a CHECK in the box for all disorders present.**

	SELF	Mother	Mother's Mother	Mother's Father	Father	Father's Mother	Father's Father	Aunts	Uncles	Siblings
Lupus										
Mononucleosis										
Multiple Sclerosis										
Obesity										
Osteoporosis										
Ovarian Cysts										
Pelvic Inflamm. Dis.										
Pneumonia										
Polycystic Ovaries										
Psychiatric Care										
Scoliosis										
Seizures										
STD'S										
Sleep Apnea										
Stomach Ulcers										
Stroke										
Suicide										
Thyroid Disease										
Tuberculosis										
Ulcerative Colitis										
Uterine Fibroids										
OTHER:										

Number of Siblings: Brothers \_\_\_\_\_

Sisters \_\_\_\_\_

What medical problems have they had?

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Number of Biological children: Sons \_\_\_\_\_

Daughters \_\_\_\_\_

What medical problems have they had?

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Number of Adopted / foster / stepchildren

Sons \_\_\_\_\_

Daughters \_\_\_\_\_

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**SURGICAL HISTORY**  
**What surgeries have you had?**

<b>SURGERY</b>	<b>YEAR/AGE</b>	<b>SURGERY</b>	<b>YEAR/AGE</b>
Abdom. Hysterectomy Why?		Heart Surgery	
Vaginal Hysterectomy Why?		Orthopedic Surgery	
Ovaries Removed		LASIK	
Dilation & Curettage (D & C)		Thyroidectomy	
Bilateral Tubal Ligation (Tubes Tied)		Tonsils/Adenoids	
C-Section		Rhinoplasty	
Laparoscopy		Septoplasty	
Mastectomy		Blepharoplasty (eyelids)	
Breast Augmentation		Face Lift	
Breast Cyst Aspiration		Hernia Repair	
Laparotomy (open abdomen)		Appendectomy	
Cholecystectomy (Gallbladder)		Wisdom Teeth	
Lithotripsy (Kidney Stones)		Vasectomy	
Gastric Bypass		Varicocoele	
Lap Band		Skin Cancer Removal	

**Other Operations:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Other Hospitalizations:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**PROCEDURE HISTORY**

Please list approximate dates and results of your most recent tests.

DATE

RESULT

Cholesterol Level:

Bone Density Scan:

EKG and /or Stress Test:

Colonoscopy:

Chest X-Ray:

Other:

PAP Smear:

Mammogram:

PSA Blood Test:

Prostate Exam:

**GYNECOLOGICAL HISTORY (FOR WOMEN ONLY)**

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

How old were you when you started your periods?  
When was your last menstrual period?  
How often do you have a menstrual period?  
How many days do they last?  
Are your periods lighter or heavier now than in the past?  
Do you get severe menstrual cramps during your periods?  
How often do you examine your breasts?  
Have you ever had a breast problem or abnormal mammogram?  
Have you ever had an abnormal PAP Smear?

YES NO

YES NO

YES NO

YES NO

**SEXUAL HISTORY (FOR BOTH MEN & WOMEN)**

YES NO  
YES NO  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever been sexually active?  
Are you currently sexually active?  
Are your partners male or female?  
Have you ever been sexually abused?  
Have you ever been physically abused?  
Have you ever had any sexually transmitted diseases?

YES NO

**OBSTETRICAL HISTORY (FOR WOMEN ONLY)**

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

How many pregnancies have you had?  
How much did your largest baby weigh at birth?  
Dates of vaginal deliveries  
Dates of C-Sections  
Number of stillbirths  
How many miscarriages?  
How many abortions?  
Number of twin or triplet pregnancies  
Did you undergo fertility treatments?  
What pregnancy complications did you have?

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**SOCIAL HISTORY**

**YES NO** Do you smoke? How many years? \_\_\_\_\_ Packs per day \_\_\_\_\_  
**YES NO** Previous smoking? How many years? \_\_\_\_\_ Packs per day \_\_\_\_\_  
 \_\_\_\_\_ When did you quit?  
**YES NO** Do you chew tobacco?  
**YES NO** Do you use illicit drugs?

What is your occupation? \_\_\_\_\_

How many hours do you work each week? \_\_\_\_\_

Do you travel outside the country? (If so, where?) \_\_\_\_\_

Do you have pets? (If so, please describe.) \_\_\_\_\_

What interests / hobbies do you have? \_\_\_\_\_

With whom do you live at home? \_\_\_\_\_

**EXERCISE**

How often do you exercise? \_\_\_\_\_

What types of exercise / physical activity do you do? \_\_\_\_\_

**DIETARY**

How many meals do you eat each day? \_\_\_\_\_

**YES NO** Do you eat breakfast?  
 If so, what do you usually eat for breakfast? \_\_\_\_\_

How many servings of these foods do you eat EACH DAY?

- \_\_\_\_\_ Fruits
- \_\_\_\_\_ Vegetables
- \_\_\_\_\_ Chicken / Fish / Turkey
- \_\_\_\_\_ Eggs
- \_\_\_\_\_ Nuts
- \_\_\_\_\_ Bread / Pasta / Potatoes / Rice / Cereals
- \_\_\_\_\_ Milk / Cheese / Yogurt
- \_\_\_\_\_ Red Meat
- \_\_\_\_\_ Processed Meats ( Deli meats, sausage, hot dogs )
- \_\_\_\_\_ Desserts / Candies / Ice Cream
- \_\_\_\_\_ Caffeinated beverages
- \_\_\_\_\_ Carbonated beverages
- \_\_\_\_\_ Alcoholic beverages

What percentage of your foods are organic? \_\_\_\_\_

How many times a week do you eat out? \_\_\_\_\_

How many times a week do you eat fast food? \_\_\_\_\_

**YES NO** Do you crave sweets?

**YES NO** Do you crave salty foods?

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**EXPOSURES**

Have you been exposed to any industrial chemicals, pesticides or other toxins? \_\_\_\_\_

Approximately how many mercury amalgam fillings do you have in your teeth? \_\_\_\_\_

How often do you take antibiotics? \_\_\_\_\_

Have you ever been treated with Prednisone? \_\_\_\_\_

**SLEEP**

\_\_\_\_\_ How many hours of sleep do you get each night?

\_\_\_\_\_ How many hours of sleep each night do you need to feel your best?

**YES NO** Do you have trouble falling asleep?

**YES NO** Do you awaken frequently during the night?

**YES NO** If so, do you have trouble getting back to sleep again?

**YES NO** Do you wake up in the early morning before it is time to get up?

**YES NO** Do you wake up feeling refreshed in the morning?

**YES NO** Do you snore?

**STRESS**

**YES NO** Do you frequently feel short of time?

**YES NO** Do you feel frustrated by present personal, relationship or work circumstances?

Please feel free to elaborate:

How much stress are you under, on a scale of 1 to 10, with 10 being highest stress? \_\_\_\_\_

Please describe ways that you cope with stress in your life:

**SELF-ASSESSMENT**

Do you see any relationship between your current condition and any aspect of your lifestyle? If so, please describe:

Do you have a religious or spiritual orientation/practice that is important to you?

If so, please feel free to elaborate:

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**REVIEW OF BODY SYSTEMS**

Please place a CHECK in front of any recent symptoms you have had.

Check	GENERAL	Check	PSYCHOLOGY
	Weight loss		Mood changes
	Weight gain		Hallucinations
	Trouble losing weight		Depressed moods
	Night sweats		Previous antidepressant therapy?
	Hot flashes		Postpartum depression
	Excessive thirst		Anxiety
	Heat intolerance		Excessive worry
	Cold intolerance		Panic attacks
	Cold hands and feet		Mental or physical abuse
	Fevers		Low libido
	Poor appetite		Loss of enjoyment of sex
	Fatigue		Sleep disturbance
	Afternoon fatigue		Decreased mental sharpness
	Exhaustion (napping does not help)		Poor memory
	Energy level on a scale of 1-10 (with 10 being highest energy) _____		Anger problems
			Personality changes
	<b>HEAD</b>		Have you noticed a decline in the following:
	Headaches		Initiative
	Dizziness		Assertiveness
			Confidence
	<b>EARS</b>		Decisiveness
	Earache		Abstract thinking
	Hearing loss		Analytical / Mathematical ability
	Ears ringing		

**DOCTOR'S NOTES:**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**REVIEW OF BODY SYSTEMS – continued**

Please place a CHECK in front of any recent symptoms you have had.

Check	EYES	Check	LUNGS
	Changes in vision		Shortness of breath
	Double vision		Coughing up blood
	Blind spots		Coughing
	Eye pain		Wheezing
	Tearing		Chest tightness
	Dry eyes		Chest congestion
	Itchy eyes		
	Drainage from eyes		<b>HEART</b>
	Swelling around eyes		Irregular heartbeat / palpitations
	Dark circles under eyes		Chest pain
			Lightheadedness
	<b>NOSE / THROAT</b>		Fainting
	Seasonal allergies		
	Nose bleeds		<b>VESSELS</b>
	Voice changes		Blood clots in veins
	Throat pain		Varicose veins
	Snoring		Phlebitis
	How many times/year do you get a cold, sore throat or chest infection? _____		Easy bruising
			Easy bleeding
	<b>MOUTH</b>		Leg swelling
	Bleeding gums		Enlarged lymph nodes
	Mouth sores		Tender lymph nodes
	Dry mouth		
	Dentures		
	Dental Problems		

**DOCTOR'S NOTES:**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**REVIEW OF BODY SYSTEMS – continued**

**Please place a CHECK in front of any recent symptoms you have had.**

Check	DIGESTION	Check	MALE REPRODUCTIVE / URINARY
	Difficulty swallowing		Jock itch
	Rectal pressure/pain		Problems maintaining an erection
	Hemorrhoids		Problems with ejaculation
	Abdominal pain		Weak urinary stream
	Heartburn		Trouble starting or stopping urine stream
	Excess gas/bloating		Previous prostate infection
	Burping		Prostate enlargement
	Yellow skin		
	Constipation		<b>FEMALE REPRODUCTIVE</b>
	Diarrhea		Vaginal discharge
	Abnormal stools		Yeast infections
	Bloody stools		Pelvic pain
	Incontinent of stool		Menstrual cramps
	Nausea		Infertility
	Vomiting		Irregular periods
	Vomiting blood		Premenstrual symptoms (PMS)
	# of bowel movements per week: _____		Heavy Periods
			Bleeding between periods
	<b>URINARY</b>		Bleeding with intercourse
	Incontinence		Birth control use in present or past
	Painful urination		Vaginal dryness
	Frequent urination		Painful intercourse
	Blood in urine		
	Urinary urgency		
	Urinary tract infections		
	Weak urine stream		
	How many times during the night do you get up to empty your bladder? _____		

**DOCTOR'S NOTES:**

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**REVIEW OF BODY SYSTEMS – continued**

Please place a CHECK in front of any recent symptoms you have had.

Check	BREASTS	Check	HAIR
	Tenderness		Changes in hair texture
	Nipple discharge		Hair loss / thinning
	Swelling		Increased body hair
	Lumps		Loss of body hair
	Fibrocystic breast disease		Increased facial hair
			Beard thinning
	<b>MUSCULOSKELETAL</b>		
	Limited motion		<b>SKIN</b>
	Muscle weakness		Change in moles
	Muscle cramps		Premature aging
	Joint pain		Nail changes
			Itching
	<b>NEUROLOGY</b>		Acne
	Speech problems		Dry skin
	Poor coordination		Rash
	Numbness		Hives
	Tremor		Foot fungus
			Excessive sweating
			Decreased sweating

**DOCTOR'S NOTES:**