

# Dr. Saleeby's Consultation Service

410 Lakeshore Drive, Bennettsville, SC 29512 - 800-965-8482 (toll free) - [www.saleeby.net](http://www.saleeby.net)

## HEALTH HISTORY FORM

### PART I. Personal Information and Medical History

SEX: CHECK ONE:  
 Male       African American  
 Female     White       Asian  
                  American Indian/Alaskan Native  
AGE: \_\_\_\_\_  Hispanic     Pacific Islander

\_\_\_\_\_  
**Last Name                      First                                      Middle Initial**

\_\_\_\_\_  
**Social Security #                      Birth date                      Place of Birth: Country    State    City**

\_\_\_\_\_  
**Mailing Address                      City/State                      Zip                      Home Telephone No.**

\_\_\_\_\_  
**Employer Work                      Telephone No.                      email address**

\_\_\_\_\_  
**Emergency Contact Person                      Relationship                      Telephone No.**

### PART II. Medications

Which of the following do you take more than once a week?  None

- |   |   |
|---|---|
| <input type="checkbox"/> Acetaminophin                | <input type="checkbox"/> Hormones                 |
| <input type="checkbox"/> Antacids                     | <input type="checkbox"/> Ibuprofen (Advil/Motrin) |
| <input type="checkbox"/> Antihistamines/allergy pills | <input type="checkbox"/> Insulin, Diabetic Pills  |
| <input type="checkbox"/> Arthritis medication         | <input type="checkbox"/> Laxatives                |
| <input type="checkbox"/> Aspirin                      | <input type="checkbox"/> Stomach/Intestinal Pills |
| <input type="checkbox"/> Birth Control Pills          | <input type="checkbox"/> Thyroid Medication       |
| <input type="checkbox"/> Blood Pressure Pills         | <input type="checkbox"/> Tranquilizers/Sedatives  |
| <input type="checkbox"/> Decongestants/Cold Pills     | <input type="checkbox"/> Vitamins                 |
| <input type="checkbox"/> Heart Medication             | <input type="checkbox"/> Weight Reduction Pills   |

List medications (prescriptions, non –prescriptions, herbals & vitamins) you currently take:

_____	_____
_____	_____
_____	_____
_____	_____

### PART III. Immunizations

Have you received the Hepatitis B Vaccine?  Yes  No

If "yes", number of shots?  1  2  3 Year completed \_\_\_\_\_

Year of last tetanus booster: \_\_\_\_\_

If born after 1956, date of last Measles booster: \_\_\_\_\_

Have you ever received (or are current) a Flu shot: \_\_\_\_\_

Have you ever received (or are current) a Pneumovax: \_\_\_\_\_

Other Immunizations: \_\_\_\_\_

**PART IV. Allergies**

To which of the following are you allergic?  None

- Drugs Specify: \_\_\_\_\_
- Dusts or Molds Specify: \_\_\_\_\_
- Pollens Specify: \_\_\_\_\_
- Animal Specify: \_\_\_\_\_
- Food Specify: \_\_\_\_\_
- Other Specify: \_\_\_\_\_

**PART V. Social History**

Have you ever used tobacco?  Yes  No

If "yes", When:  Current  Past – years since quitting  
Type:  Cigarettes  Pipe  Cigar  Snuff/Chewing

How many per day? \_\_\_\_\_ For how many years? \_\_\_\_\_

What is your average alcohol consumption per week? \_\_\_\_\_ drinks

How often do you drink alcohol?  Weekdays  Weekends  Both

Have you ever used recreational drugs?  Yes  No What? \_\_\_\_\_

Exercise: Y N What type: \_\_\_\_\_ Aerobic: \_\_\_\_\_ hr/wk Weight Bearing: \_\_\_\_\_ hr/wk

**PART VI. Medical History**

Which of the following conditions have you ever had?

Enter year of diagnosis if known, or place check if unknown

- |  |   |
|--|---|
| <input type="checkbox"/> Head injury         | <input type="checkbox"/> Positive skin test for TB    |
| <input type="checkbox"/> Migraines           | <input type="checkbox"/> Active Tuberculosis          |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Ulcers                       |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Hepatitis                    |
| <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Gallstones                   |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Bladder Infections           |
| <input type="checkbox"/> Thyroid trouble     | <input type="checkbox"/> Kidney Stones                |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Arthritis                    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gout                         |
| <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Herniated Disc               |
| <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Anemia                       |
| <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> Tumors                       |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Cancer                       |
| <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Depression/anxiety           |

Other medical/psychiatric disorders – Specify:

\_\_\_\_\_

\_\_\_\_\_

**PART VII. Hospitalizations and Surgeries**

**Year Reason**

Year	Reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**PART VIII. Family History**

	YES	NO	AGE AT DEATH	CAUSE OF DEATH
Is your mother living?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Is your father living?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Which of the following have your parents, brothers, sisters, or children ever had?

- |   |   |
|---|---|
| <input type="checkbox"/> Thyroid disease          | <input type="checkbox"/> Depression/suicide         |
| <input type="checkbox"/> Heart trouble or disease | <input type="checkbox"/> Other Psychiatric Diseases |
| <input type="checkbox"/> Cancer or leukemia       | <input type="checkbox"/> Alcoholism                 |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Asthma                     |
| <input type="checkbox"/> Kidney Trouble           | <input type="checkbox"/> Genetic Diseases           |
| <input type="checkbox"/> High Cholesterol         | <input type="checkbox"/> Stroke                     |

**PART IX. Occupational History**

Briefly describe the activities of your current job:

\_\_\_\_\_

\_\_\_\_\_

How long have you been doing this type of work? \_\_\_\_\_ years

Have you ever been off the job more than a day because of work related illness or injury?

Yes  No

Specify: \_\_\_\_\_

List any occupational exposures you have had (e.g. noise, chemicals, etc.)

\_\_\_\_\_

**PART X. Review of Systems – Which of the following have been a problem for you in the last year?**

**General/Constitutional**

- Fever, >101° F
- Night sweats
- Shivering chills
- Generalized weakness
- Unexplained weight loss/gain
- Excessive fatigue
- Swollen glands
- Loss of appetite

**Genitourinary/Reproductive**

- Difficult or painful urination
- Blood in urine
- Loss of bladder control
- Frequent urination
- Difficulty in having children

**(Men only)**

- Prostrate trouble
- Testicular disorder
- Penile discharge
- Impotence

**(Women only)**

- Irregular periods/spotting
- Vaginal discharge
- Miscarriage/stillborn pregnancy
- Breast lump/discharge
- D.E.S. exposure
- Currently or possibly pregnant
- Last Pap smear \_\_\_\_\_
- Last Period \_\_\_\_\_

**Heart**

- Chest pain or pressure
- Irregular heart beat
- Palpitations/skipped beats

**Lungs**

- New or change in cough
- Coughing up blood
- Wheezing
- Shortness of breath

**Digestive System**

- Nausea/vomiting
- Heartburn
- Diarrhea
- Constipation
- Yellow jaundice
- Rectal bleeding/black tarry stools
- Hemorrhoids

**Neurologic/Psychiatric**

- Headaches
- Dizziness
- Passing out/fainting
- Numbness or tingling
- Excessive sadness
- Excessive anxiety
- Insomnia/difficulty sleeping
- Loss of memory

**Skin/Musculoskeletal**

- Back pain
- Neck pain
- Joint pain
- Moles-changing
- Rashes
- Weakness in arm/leg

**Eyes**

- Vision change
- Itching
- Tearing

**Ears,Nose,Throat**

- Earaches
- Difficulty hearing
- Ringing, buzzing
- Sinus trouble
- Congestion
- Sneezing/runny nose
- Nosebleeds
- Mouth sores
- Hoarseness
- Difficulty swallowing

Rank each category (circle one) 1= poor, 3= average, 5=excellent

Energy level	1	2	3	4	5
Libido	1	2	3	4	5
Cognition	1	2	3	4	5
Fitness	1	2	3	4	5

The Information provided above in factual to the best of my knowledge.

\_\_\_\_\_  
Signature of Patient

---

## Dr. Saleeby's Consultation Service Waiver

410 Lakeshore Drive  
Bennettsville, SC 29512  
(800) 965-8482

### Waiver

I the undersigned do agree and consent to all medical treatment and services provided by Dr. Yusuf (J.P.) Saleeby and his staff. Medical Services are defined as any and all diagnostics and treatments and diagnosis provided by the Saleeby or his staff. This includes but is not limited to exercise programs, medicinal and alternative therapies, drug therapy, and any and all efforts to diagnose and treat any condition of myself. I further understand that the Dr. Saleeby's Consultation service is not a walk in, or emergency services clinic and deals with specialized diagnostics and protocols. In the event that an emergency care need arises, I realize I must go to a medical facility qualified to treat such conditions. I understand that any medical services provided to me by Dr. Saleeby do not constitute those for life threatening situations.

I agree to hold harmless and indemnify the Dr. Saleeby, Vita Sanus, Inc. and its professionals from any and all claims involving the medical services provided by this service. Further, I understand that Dr. Saleeby does not guarantee results and will not assure me progress of any condition or conditions I may have. I understand that successful treatment with Dr. Saleeby's recommendations is primarily based on my own decisions and life choices.

I agree that payment is considered due in full at the time of services or before. Payment may be made with cash, check or certified check. I understand Dr. Saleeby will not file any type of Insurance, but can provide me with the necessary codes to do so myself.

I acknowledge that this agreement has been fully read and I understand its content.

---

### ***If this pertains to you: Medicare / Medicaid Agreement***

I the undersigned do agree and understand that all treatment and services provided to me by Dr. Yusuf (J.P.) Saleeby and staff are voluntary services provided for my personal benefit. **I understand that these services are not covered by Medicare Parts A or B.** I agree therefore to pay **as fee-for-service** and not file under Medicare or Medicaid.

I understand that Dr. Saleeby does not submit claims to insurance for reimbursement and that includes Medicare / Medicaid.

I acknowledge that this agreement is fully understood in its content.

---

Patient's signature

\*\*\*Please fill out forms and mail back to **410 Lakeshore Drive, Bennettsville, SC 29512**\*\*\*.

Dr. Saleeby will review and call you for Consultation Appointment. Payment is due in full prior to consultation.