HEALTH HISTORY

Date _____
NAME _____
Name you prefer to be called_____

ALLERGIES: Meds_____
ALLERGIES: Foods/Environment_____
Age____ Height_____Sex ___
Marital Status: [ ] Single [ ] Partner [ ] Married [ ] Separated [ ] Divorced [ ] Widow(er)
Number & Ages of Children_____ Occupation _____

DATE ISSUES BEGAN:_____ DESCRIBE MAIN REASON FOR OFFICE VISIT: _____
_____
_____

List current health problems for which you are being treated:
_____
_____
_____

What types of therapies have you tried for these problem(s) or to improve your health over-all:
[ ] diet modification [ ] fasting [ ] vitamins/minerals [ ] herbs [ ] homeopathy [ ] chiropractic [ ] acupuncture
[ ] conventional medications_____
[ ] other _____

Do you experience any of these general symptoms nearly every day?
[ ] Debilitating fatigue [ ] Shortness of breath [ ] Insomnia [ ] Constipation [ ] Chronic pain/inflammation
[ ] Depression [ ] Panic attacks [ ] Nausea [ ] Fecal incontinence [ ] Bleeding
[ ] Disinterest in sex [ ] Headaches [ ] Vomiting [ ] Urinary incontinence [ ] Discharge
[ ] Disinterest in eating [ ] Dizziness [ ] Diarrhea [ ] Low grade fever [ ] Itching/rash

CURRENT MEDICATIONS AND DOSAGES (prescription or over-the-counter):
_____
_____
_____

MAJOR HOSPITALIZATION, SURGERIES, INJURIES: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	
_____	_____	
_____	_____	
_____	_____	

Last date you had a comprehensive physical examination: _____ Last lab work date _____

Circle the level of stress you are experiencing on a scale of 1to 10 (1 being the lowest):1 2 3 4 5 6 7 8 9 10
Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems):_____

Do you consider yourself: [ ] underweight [ ] overweight [ ] just right

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? [ ] yes [ ] no

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)? List_____

INDICATE HOW COMMITTED YOU ARE TO IMPROVING YOUR HEALTH AS SOON AS POSSIBLE:
NOT READY –0-----1-----2------3------4------5------6------7------8------9------10—MUST GET BETTER NOW

MEDICAL HISTORY
[ ] Acne
[ ] Arthritis
[ ] Allergies/hay fever
[ ] Asthma
[ ] Alcoholism
[ ] Alzheimer's disease
[ ] Autoimmune disease
[ ] Blood pressure problems
[ ] Bronchitis
[ ] Cancer
[ ] Chronic fatigue
[ ] Carpal tunnel syndrome
[ ] Cholesterol, elevated
[ ] Circulatory problems
[ ] Colitis
[ ] Dental issues
[ ] Depression
[ ] Diabetes
[ ] Diverticulitis
[ ] Drug addiction
[ ] Eating disorder
[ ] Epilepsy
[ ] Emphysema
[ ] Eye problems
[ ] Ear problems
[ ] Environmental sensitivities
[ ] Fibromyalgia
[ ] Food intolerance
[ ] Heartburn/ reflux
[ ] Glaucoma
[ ] Gout
[ ] Heart disease
[ ] Inflammatory bowel disease
[ ] Irritable bowel syndrome
[ ] Kidney/bladder disease
[ ] Learning disabilities
[ ] Liver or gallbladder disease (stones)
[ ] Memory difficulty
[ ] Mental illness
[ ] Migraine headaches
[ ] Numbness
[ ] Sinus problems
[ ] Stroke
[ ] Thyroid trouble
[ ] Obesity
[ ] Osteoporosis
[ ] Pneumonia
[ ] Seasonal affective disorder
[ ] Skin problems
[ ] Tremors
[ ] Tuberculosis
[ ] Ulcer
[ ] Urinary tract infections
[ ] Varicose veins
[ ] Muscle Weakness

MEDICAL (MEN)
[ ] Prostate enlargement
[ ] Prostate cancer
[ ] Decreased sex drive
[ ] Infertility
[ ] Sexually transmitted disease
Prostate exam date_____

MEDICAL (WOMEN)
[ ] Menstrual irregularities
[ ] Endometriosis
[ ] Infertility
[ ] Fibrocystic breasts
[ ] Fibroids/ovarian cysts
[ ] Premenstrual syndrome (PMS)
[ ] Breast cancer
[ ] Pelvic inflammatory disease
[ ] Vaginal infections
[ ] Decreased sex drive
[ ] Sexually transmitted disease
[ ] Hysterectomy
[ ] Menopause
Other _____
Date of last GYN exam _____
Mammogram date _____
PAP date_____
Form of birth control: _____

FAMILY HEALTH HISTORY
(Parents and Siblings)
[ ] Arthritis
[ ] Asthma
[ ] Alcoholism/drug use
[ ] Alzheimer's disease
[ ] Autoimmune disease
[ ] Cancer
Type_____
[ ] Cholesterol
[ ] Depression
[ ] Diabetes
[ ] Eating disorder
[ ] Fibromyalgia
[ ] Genetic disorder
[ ] Glaucoma
[ ] Heart disease
[ ] High blood pressure
[ ] Mental illness
[ ] Mental retardation
[ ] Migraine headaches
[ ] Neurological disorders (i.e. Parkinson's,Paralysis, MS, tremors)
[ ] Obesity
[ ] Osteoporosis
[ ] Stroke
[ ] Suicide

HEALTH HABITS
[ ]Tobacco:
Cigarettes: #/day ____
Cigars: #/day ____
[ ]Alcohol:
Wine: #glasses/d or wk___
Liquor: #oz/d or wk_____
Beer: #glasses/ d or wk ___
[ ] Caffeine:
Coffee: #6 oz cups/ d ____
Tea: #6 oz cups/d _____
Soda: #cans/d_____
Other sources_____
[ ] Water: #glasses/d____
Exercise
[ ] 5-7 days per week
[ ] 3-4 days per week
[ ] 1-2 days per week
[ ] 45 minutes or more duration per workout
[ ] 30-45 minutes duration per workout
[ ] Less than 30 minutes
[ ] Walk-#days/wk_____
[ ] Run, jog, other aerobic #days/wk_____
[ ] Weight lift #days/wk_____
[ ] Stretch - #days/wk
[ ]Other_____

Please check any of the following that have been occurring in the last 3 months, or have occurred frequently in your life.

[ ]Frequent use of antibiotics
[ ]Ever used prednisone/steroids
[ ]Ever used birth control pills
[ ]I feel worse with exercise
[ ]I feel better with exercise
[ ]Head hair loss
[ ]Body hair loss/increase
[ ]Shaky/irritable when hungry
[ ]Dizzy when going from lying to standing
[ ]Itchy/flaky scalp or eyebrows
[ ]Itchy/flaky ears
[ ]Itchy anus
[ ]Thickened/dark toenails
[ ]Frequent vaginal or prostate infections
[ ]Frequent jock itch or athlete's foot
[ ]Poor stress tolerance
[ ]Often feel overwhelmed
[ ]Salt cravings
[ ]Sugar or bread cravings
[ ]Sensitivity to odors, perfumes, chemicals
[ ]Reactions to many medications
[ ]Feel worse with alcohol
[ ]Symptoms worse in moldy places
[ ]Reactions to tobacco smoke

NUTRITION & DIET
[ ] Mixed food diet (animal & vegetable sources)
[ ] Vegetarian
[ ] Vegan
[ ] Salt restriction
[ ] Fat restriction
[ ] Starch/carbohydrate restriction
[ ] Total calorie restriction
Specific food restrictions:
[ ] dairy [ ] wheat
[ ] eggs [ ] soy [ ] corn
[ ] all gluten
Other _____

CURRENT SUPPLEMENTS
[ ] Multivitamin/mineral
[ ] Vitamin C
[ ] Vitamin D
[ ] fish oil or EPA/DHA
[ ] Evening Primrose/GLA [ ] Calcium, source
[ ] Magnesium
[ ] Zinc
[ ] Minerals
[ ] Friendly flora/probiotics (acidophilus)
[ ] Digestive enzymes
[ ] Amino acids
[ ] COQ1O
[ ] Antioxidants (e.g., lutein, resveratrol, etc.)
[ ] Herbs
[ ] Homeopathy
[ ] Protein shakes
[ ] Superfoods (e.g., bee pollen, phytonutrients)
[ ] Liquid meals
Other _____