

HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____ Date began: _____

—
—

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

—
Outcome _____

What types of therapy have you tried for this problem(s):

diet modification fasting vitamins/minerals herbs homeopathy chiropractic acupuncture conventional drugs
others _____

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

—
Current medications (prescriptions or over the counter): _____

Major hospitalizations, surgeries, injuries: (Please list all procedures, complications, (if any) and dates:

Year	Surgery, illness, injury	Outcome
------	--------------------------	---------

—
—

Circle the level of stress you are experie

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 your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and life threatening activities (e.g., line-man, farmer, minor)?

—
 Corrective lenses Dentures Hearing aid Medical devices/prosthetics, implants, describe: _____

Recent changes in your ability to: see hear taste smell feel hot/cold sensations
 move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: sour bitter sweet rich/fatty spicy/pungent salty

Strong dislike for any of the following flavors: sour bitter sweet rich/fatty spicy/pungent salty

Do you: Prefer warmth (i.e., food, drinks, weather, etc.) Prefer cold (i.e., food, drinks, weather, etc.) No preference

Is our sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

- 7a.m.-9a.m. 9a.m.-11a.m. 11a.m.-1p.m.
- 1p.m.-3p.m. 3p.m.-5p.m. 5p.m.-7p.m.
- 7p.m.-9p.m. 9p.m.-11p.m. 11p.m.-1a.m.
- 1a.m.-3a.m. 3a.m.-5a.m. 5a.m.-7a.m.

Time of day you feel the worst or your symptoms are aggravated:

- 7a.m.-9a.m. 9a.m.-11a.m. 11a.m.-1p.m.
- 1p.m.-3p.m. 3p.m.-5p.m. 5p.m.-7p.m.
- 7p.m.-9p.m. 9p.m.-11p.m. 11p.m.-1a.m.
- 1a.m.-3a.m. 3a.m.-5a.m. 5a.m.-7a.m.

Do you experience any of these general symptoms EVERY DAY?

- | | | | | |
|--|--|-----------------------------------|---|--|
| <input type="checkbox"/> Debilitating fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic pain/inflammation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Nausea | <input type="checkbox"/> Fecal incontinence | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Disinterest in sex | <input type="checkbox"/> Headaches | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Disinterest in eating | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Low grade fever | <input type="checkbox"/> Rash |

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Other _____
- Age of first period _____
- Date of last gynecological exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section
- Surgical menopause
- Menopause
- Date of last menstrual cycle: _____
- Length of cycle _____ days
- Interval of time between cycle _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots) _____

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Obesity
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco
- Cigarettes: #/day _____
- Cigars: #/day _____
- Alcohol:
- Wine: # glasses/day _____
- Liquor: # ounces/day _____
- Beer: # glasses/day _____
- Caffeine:
- Coffee: # 6oz. cups/day _____
- Tea: # 6oz. cups/day _____
- Soda w/ caffeine: # cans/day _____
- Other sources: _____
- Water: # glass/day _____
- 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
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
- dairy wheat eggs
- soy corn all gluten

Food Frequency

- Servings per day: _____
- Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables: _____
- Grains (unprocessed): _____
- Beans, peas, legumes: _____
- Dairy, eggs: _____
- Meat, poultry, fish: _____

Eating Habits

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

Current Supplement

- Multi vitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g. lutein, resveratrol, etc.)
- Herbs-teas
- Herbs-extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods, (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other _____

Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)