Health History Form

Name:_____ Date: _____

Address:_____

City: _____ State: _____ Zip Code:_____

Telephone # (home):_____ (cell):_____

E-mail address:_____

Age: _____ Date of Birth: _____ Gender: female ____male____

Married: ____ Separated:____ Divorced: ____ Widowed: _____ Single:____ Partnership:____

Live with: Spouse ____Partner ____Parents ____Children___ Friends ____Alone ____

Occupation: _____ Hours per week: _____Retired: ____

(Work address): _____

How did you hear about our clinic? _____

Person to reach in an emergency: _____

Relationship: _____ Phone: _____

What are your most important health problems? List as many as you can in order of importance:

1)
2)
3)
4)

Childhood Illnesses

Scarlet Fever	Y N	Diphtheria	Y N	Rheumatic fever	Y N
Mumps	Y N	Measles	Y N	German Measles	Y N

Hospitalizations and Surgery

What hospitalizations or surgeries have you had?

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

X-rays and Special Studies

X-rays, CAT scans, or other studies you have had:

_____

_____

Electrocardiogram Y N

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Dipthreia	Y N
Measles/Mumps/Rubella	Y N	Chikenpox	Y N
Hepatitis	Y N	Other: _____	

Allergies

Are you hypersensitive or allergic to …

Any drugs? _____

Any foods? _____

Any environmental or chemical sensitivities? _____

Current Medications

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping Pills	Y N

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are taking.

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

General

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.
Maximum Weight: _____ When: _____
When during the day is your energy the best? _____ worst? _____

Typical Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Family History

Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart disease	High blood pressure	Kidney disease
Epilepsy	Arthritis	Glaucoma	Tuberculosis	Stroke
Anemia	Mental Illness	Asthma	Hay fever	Hives

Any other relevant family history? _____

_____

Y = a condition you **have now** **N** = a condition you **never had** **P** = a condition you have **had in the past**

Habits

Main interests and hobbies? _____

Do you exercise? Y N

If yes, what kind? _____

Average 6-8 hrs. sleep	Y	N		Enjoy your work	Y N
Awaken rested	Y	N		Take vacations	Y N
Have a supportive relationship?	Y	N		Watch television	Y N
Have a history of abuse	Y	N		how many hours? _____	
Any major traumas	Y	N	P	Read	Y N
Use recreation drugs	Y	N	P	how many hours? _____	
Been treated for drug dependence	Y	N	P	Do you eat 3 meals a day	Y N
Use alcoholic beverages	Y	N	P	Do you go on diets often	Y N P
Treated for alcoholism	Y	N	P	Do you eat out often	Y N P
Do you use tobacco	Y	N	P	Do you drink coffee	Y N P
Smoked previously	Y	N	P	Drink black/green tea	Y N P
How many years? _____				Do you drink cola/soda	Y N P
How many packs per day? _____				Do you eat refined sugar	Y N P
				Do you add salt	Y N P

Do you have a religious or spiritual practice? Y N

For the following, please circle

Y = a condition you **have now** **N** = a condition you **never had** **P** = a condition you have **had in the past**

Review of Systems

Mental/Emotional

Treated for emotional problems	Y	N	P	Depression	Y N P
Mood Swings	Y	N	P	Anxiety or nervousness	Y N P
Considered/Attempted suicide	Y	N	P	Tension	Y N P
Poor concentration	Y	N	P	Memory Problems	Y N P

Immune

Reactions to immunizations	Y	N	P	Reactions to vaccinations	Y N P
Chronic Fatigue Syndrome	Y	N	P	Chronic/Recurring infections	Y N P
Chronically swollen glands	Y	N	P	Slow wound healing	Y N P

Endocrine

Hypothyroid	Y	N	P	Heat or cold intolerance	Y	N	P
Hypoglycemia	Y	N	P	Diabetes	Y	N	P
Excessive thirst	Y	N	P	Excessive Hunger	Y	N	P
Fatigue	Y	N	P	Seasonal Depression	Y	N	P

Neurologic

Seizures	Y	N	P	Paralysis	Y	N	P
Muscle weakness	Y	N	P	Numbness or tingling	Y	N	P
Loss of memory	Y	N	P	Easily stressed	Y	N	P
Vertigo or dizziness	Y	N	P	Loss of balance	Y	N	P

Skin

Rashes	Y	N	P	Eczema, Hives	Y	N	P
Acne, Boils	Y	N	P	Itching	Y	N	P
Color Change	Y	N	P	Perpetual hair loss	Y	N	P
Lumps	Y	N	P	Night Sweats	Y	N	P

Head

Headaches	Y	N	P	Head Injury	Y	N	P
Migraines	Y	N	P	Jaw/TMJ problems	Y	N	P

Eyes

Spots in Eyes	Y	N	P	Cataracts	Y	N	P
Impaired vision	Y	N	P	Glasses or contacts	Y	N	P
Blurriness	Y	N	P	Eye pain/strain	Y	N	P
Color blindness	Y	N	P	Tearing or dryness	Y	N	P
Double vision	Y	N	P	Glaucoma	Y	N	P

Ears

Impaired hearing	Y	N	P	Ringing	Y	N	P
Earaches	Y	N	P	Dizziness	Y	N	P

Nose and Sinuses

Frequent colds	Y	N	P	Nose Bleeds	Y	N	P
Stuffiness	Y	N	P	Hay fever	Y	N	P
Sinus problems	Y	N	P	Loss of smell	Y	N	P

Mouth and Throat

Frequent sore throat	Y	N	P	Copious saliva	Y	N	P
Teeth grinding	Y	N	P	Sore tongue/lips	Y	N	P
Gum problems	Y	N	P	Hoarseness	Y	N	P
Dental cavities	Y	N	P	Jaw clicks	Y	N	P

Neck

Lumps	Y	N	P	Swollen glands	Y	N	P
Goiter	Y	N	P	Pain or stiffness	Y	N	P

Respiratory

Cough	Y	N	P	Sputum	Y	N	P
Spitting up blood	Y	N	P	Wheezing	Y	N	P
Asthma	Y	N	P	Bronchitis	Y	N	P
Pneumonia	Y	N	P	Pleurisy	Y	N	P
Emphysema	Y	N	P	Difficulty breathing	Y	N	P
Shortness of breath at night	Y	N	P	Shortness of breath	Y	N	P
Tuberculosis	Y	N	P	“ “ “ lying down	Y	N	P

Cardiovascular

Heart disease	Y	N	P	Angina	Y	N	P
High/Low blood pressure	Y	N	P	Murmurs	Y	N	P
Blood clots	Y	N	P	Fainting	Y	N	P
Phlebitis	Y	N	P	Palpitations/Fluttering	Y	N	P
Rheumatic Fever	Y	N	P	Chest Pain	Y	N	P
Swelling in ankles	Y	N	P				

Gastrointestinal

Trouble swallowing	Y	N	P	Heartburn	Y	N	P
Change in thirst	Y	N	P	Abdominal pain or cramps	Y	N	P
Change in appetite	Y	N	P	Belching or passing gas	Y	N	P
Nausea/vomiting	Y	N	P	Constipation	Y	N	P
Ulcer	Y	N	P	Diarrhea	Y	N	P
Jaundice(Yellow Skin)	Y	N	P	Bowel movements: How often? _____			
Gall Bladder disease	Y	N	P	Is this a change? _____			
Liver Disease	Y	N	P	Black Stools	Y	N	P
Hemorrhoids	Y	N	P	Blood in stool	Y	N	P

Urinary

Pain on urination	Y	N	P	Increased frequency	Y	N	P
Frequency at night	Y	N	P	Inability to hold urine	Y	N	P
Frequent infections	Y	N	P	Kidney stones	Y	N	P

Musculoskeletal

Joint pain or stiffness	Y	N	P	Arthritis	Y	N	P
Broken bones	Y	N	P	Weakness	Y	N	P
Muscle spasm or cramps	Y	N	P	Sciatica	Y	N	P

Blood/Peripheral Vascular

Easy bleeding or bruising	Y	N	P	Anemia	Y	N	P
Deep leg pain	Y	N	P	Cold hands/feet	Y	N	P
Varicose veins	Y	N	P	Thrombophlebitis	Y	N	P

Male Reproduction

Hernias	Y	N	P	Testicular masses	Y	N	P
Testicular Pain	Y	N	P	Prostate Disease	Y	N	P
Venereal disease	Y	N	P	Discharge or sores	Y	N	P
Are you sexually active?	Y	N		Gonorrhea	Y	N	P
Sexual orientation: _____				Chlamydia	Y	N	P
Impotence	Y	N	P	Genital warts	Y	N	P
Herpes	Y	N	P	Syphilis	Y	N	P

Female Reproduction / Breasts

Age of first menses _____				Date of last annual exam/PAP _____			
Age of last menses(if menopausal) _____				Are cycles regular	Y	N	P
Length of cycle _____ days				Spotting between cycles	Y	N	P
Duration of menses _____ days				Pain during intercourse	Y	N	P
Painful menses	Y	N	P	Clotting	Y	N	P
Heavy or excessive flow	Y	N	P	Discharge	Y	N	P
PMS	Y	N	P	Birth Control	Y	N	P
If yes, what are your symptoms				What type _____			
_____				Number of pregnancies _____			
				Number of live births _____			
_____				Number of miscarriages _____			
Endometriosis	Y	N	P	Number of abortions _____			
Ovarian cysts	Y	N	P	Menopausal symptoms	Y	N	P

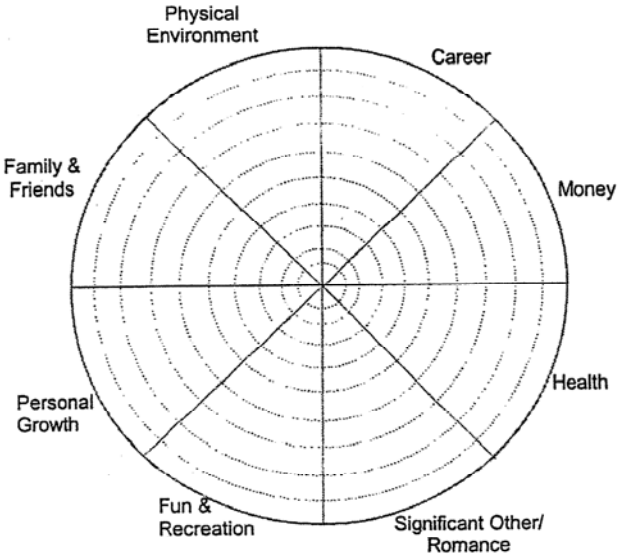
Difficulty conceiving	Y	N	P	Abnormal PAP	Y	N	P
Cervical Dysplasia	Y	N	P	Chlamydia	Y	N	P
Sexual Difficulties	Y	N	P	Genital warts	Y	N	P
Herpes	Y	N	P	Syphilis	Y	N	P
Are you sexually active	Y	N		Sexual orientation _____			
Do you do breast self exams	Y	N	P	Breast lumps	Y	N	P
Breast pain/tenderness	Y	N	P	Nipple discharge	Y	N	P

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



Example: