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Health History Form

Name:____ Date: _________

Address:____

City: ________________________________ State: ________ Zip Code:___________

Telephone # (home):__________________________

E-mail address:____________________________

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

Education: ____

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

Live with: Spouse ____Partner ____Parents ____Children___ Friends ____Alone ____

Occupation: _______________________________ Hours per week: _______Retired: ____

Employer: ____________________________________ S.S.#: ____________________

(Work address): ____

How did you hear about our clinic? _________________________________

____

Has any other family member already been a patient at the clinic? ___________

Person to reach in an emergency: _______________________________

Relationship: __________________________________ Phone: __________________

Address: ____

____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the provider has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1) Why did you choose to come to this clinic?

- What do you know about our approach?

2) What three expectations do you have from this visit to our clinic?

- What long term expectations do you have from working with our clinic?

- What expectations do you have of me personally as your doctor?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed.)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

4) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

5) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

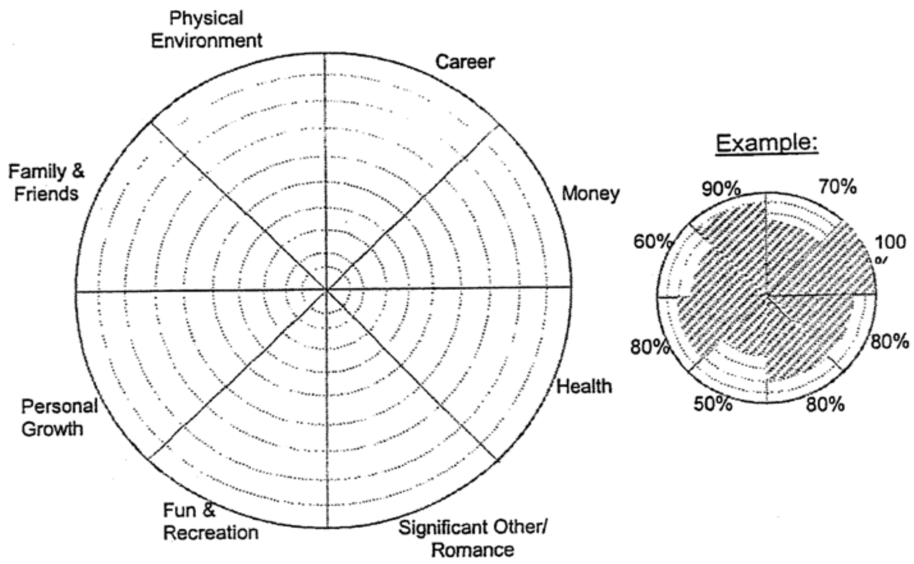
6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

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.



Are you currently receiving health care? Y N

If yes, where and from whom: ____

____

If no, when and where did you last receive medical or health care?_________________

____

What was the reason? ____

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

1)
2)
3)
4)
5)
6)
7)

Do you have any, known contagious diseases at this time? Y N

If yes, what? ____

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	Diptheia	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	Hayfever	Hives

What is your heritage? German _________ Nordic ________ Celtic __________ Other_______

Any other relevant family history? ____

____

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**

Habits

Main interests and Hobbies? ____

Do you exercise? Y N

If yes, what kind? ____

Average 6-8 hrs. sleep	Y N		Enjoy you 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

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	Hayfever	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	Difficultly 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 ______________

Age of last menses(if menopausal) ___________

Length of cycle _____________________ days

Duration of menses __________________ days

Painful menses	Y N P
Heavy or excessive flow	Y N P
PMS	Y N P

If yes, what are your symptoms

____

____

Endometriosis	Y N P
Ovarian cysts	Y N P
Difficulty conceiving	Y N P
Cervical Dysplasia	Y N P
Sexual Difficulties	Y N P
Herpes	Y N P
Are you sexually active	Y N
Do you do breast self exams	Y N P
Breast pain/tenderness	Y N P

Date of last annual exam/PAP ___________

Are cycles regular	Y N P
Spotting between cycles	Y N P
Pain during intercourse	Y N P
Clotting	Y N P
Discharge	Y N P
Birth Control	Y N P

What type ___________________________

Number of pregnancies _________________

Number of live births ___________________

Number of miscarriages _________________

Number of abortions ____________________

Menopausal symptoms	Y N P
Abnormal PAP	Y N P
Chlamydia	Y N P
Genital warts	Y N P
Syphilis	Y N P

Sexual orientation ____________________

Breast lumps	Y N P
Nipple discharge	Y N P

Is there anything else you would like to comment on?

Your time and effort is greatly appreciated. I look forward to helping you reach your highest health goals.