

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?

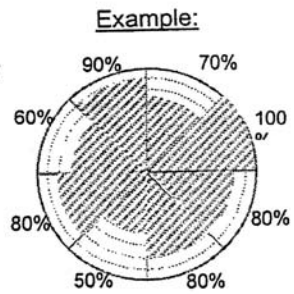
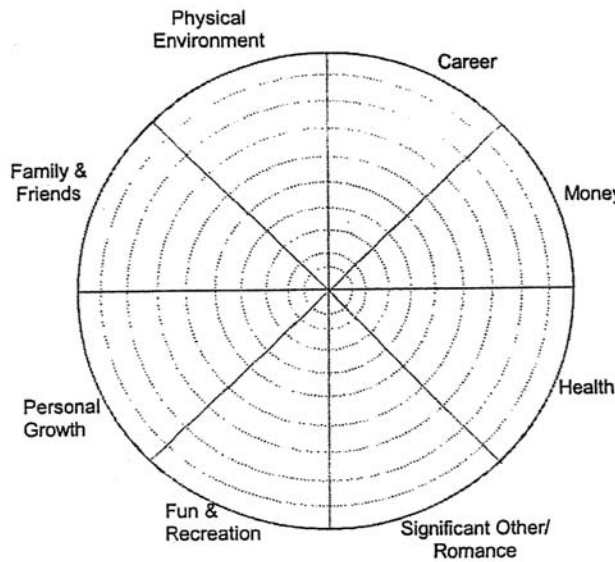
6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

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) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____
- 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
		Y N	

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
Stiffness	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 _____		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 _____	
_____		Number of abortions _____	
Endometriosis	Y N P	Menopausal symptoms	Y N P
Ovarian cysts	Y N P	Abnormal PAP	Y N P
Difficulty conceiving	Y N P	Chlamydia	Y N P
Cervical Dysplasia	Y N P	Genital warts	Y N P
Sexual Difficulties	Y N P	Syphilis	Y N P
Herpes	Y N P	Sexual orientation _____	
Are you sexually active	Y N	Breast lumps	Y N P
Do you do breast self exams	Y N P	Nipple discharge	Y N P
Breast pain/tenderness	Y N P		

Is there anything else you would like to comment on?

Your time and effort is greatly appreciated. I look forward to serving you.