Health & History

This is a confidential record of your personal and medical history and will be kept CONFIDENTIAL. Information herein will not be released to any person unless you have authorized me to do so in writing. Please take your time and complete as thoroughly as possible.

PERSONAL INFORMATION

Name _____

DOB (xx/xx/xx) _____ Birth Time_____(am/pm) Birthplace_____

Address_____ City _____State ____ Zip _____

Best Phone _____

Occupation _____

Marital Status _____

Children (#/ages) _____

Do you have primary concerns?

_____

_____

_____

_____

Are you currently taking any medications/prescriptions? YES _____ NO _____

Please list them here OR use the detailed form_____

_____

_____

Are you currently receiving medical care from any other health professional? YES _____ NO _____

Name or Practice:

_____

What condition(s)?

_____

Do you have any infectious diseases that you know of? YES _____ NO _____

If yes, please list them:

_____

Are you pregnant? YES _____ NO _____

If yes, how many months? _____ What is your anticipated delivery date: _____

Do you have any known allergies or sensitivities? If so, please list them:

_____

_____

Have you ever been hospitalized or had any surgeries? If so, please note approx. date and reason:

_____

_____

_____

FAMILY HISTORY (please complete this section only for family members with major health issues)

AGE (If deceased, age at death and cause)

Father _____

Mother_____

Siblings_____

Children_____

Other close blood relatives_____

YOUR PERSONAL HEALTH:

Height _____ Current Weight _____ Approx Weight 1 year ago _____

Do you smoke? YES _____ NO _____ How many years? _____ Amount daily _____

Do you drink alcohol? YES _____ NO _____ What? _____ Frequency _____

Do you use recreational drugs? YES _____ NO _____ What? _____ Frequency _____

Do you drink coffee? YES _____ NO _____ How many cups/oz? _____ Frequency _____

Do you exercise regularly? YES _____ NO _____ Sometimes _____Frequency _____

Type of exercise _____ Duration? _____

HEALTH CONCERNS: what are the major things you have experienced in the past year, or are experiencing now?

SKIN & HAIR

__Rashes __Eczema __Pimples/Hives

__Itching __Hair Loss __Moles/Poor healing sores

__Dandruff __Change in skin texture Circle Skin Type: Dry/Average/Oily

HEAD, EYES, EARS, NOSE & THROAT

__Poor vision __Cataracts __Glaucoma

__Earaches __Blurred Vision __Poor hearing

__Ringing in the ears __Sore throat __Canker sores

__Cold sores __Grinding teeth __Nose bleeds

__Facial pain __Clicking jaw __Eye pain

__Sinus congestion __Mucous in throat __Swollen glands

__Ear infections __Dizziness __Frequent colds

__Spots in front of eyes

CARDIOVASCULAR

__High Blood Pressure __Low Blood Pressure __Chest pain

__Irregular heart beat __Fainting __Palpitations

__Cold hands or feet

RESPIRATORY

__Cough __Bronchitis __Asthma

__Coughing blood __Pneumonia __Pain on breathing

__Shortness of breath without exertion __Difficulty breathing

__Production of phlegm YES _____ NO _____ If yes, what color? _____

DIGESTIVE & GASTROINTESTINAL

__Nausea __Hemorrhoids __Black stools

__Constipation __Food cravings __Indigestion

__Abdominal pain __Difficulty swallowing __Mucous in stools

__Blood in stools __Vomiting __Gas

__Poor appetite __Bad breath __Bloating

__Heartburn __Food allergies __Diarrhea

__Rectal pain

# of bowel movements daily _____ Circle One Average Texture: Loose/Normal/Hard pebble-like/Inconsistent

Any dietary restrictions or preferred diet? YES _____ NO _____ Please specify: _____

URINARY

__Painful urination __Frequent urination __Blood in urine

__Urinary urgency __Kidney stones __Irregular flow

__Incontinence __Inability to hold urine __Decreased flow

__Difficulty starting/stopping/slow __ Dark color, odorous

MUSCULOSKELETAL

__Neck pain __Muscle pain __Stiffness

__Back pain __Muscle weakness __Reduced range of motion

REPRODUCTIVE

__Average length of cycle: _____ __Perimenopause __Menopause

__Duration of bleeding: _____ __Heavy bleeding __Cramps

__Pain with intercourse __Discharges __Clots

__Unusual bleeding __Irregular cycles __Color: brown / black / bright red

__ Birth control? _____

__Migraines? YES _____ NO _____ Duration/frequency: _____

NEUROPSYCHOLOGICAL

__Poor sleep
__Depression
__Seizures
__Headaches
__Lack of coordination
__Loss of balance
__Poor memory
__Irritability
__High stress levels
__Difficulty concentrating
__Spacey / Foggy feeling
__Numbness
__Anxiety
__Migraine

Average hours of sleep _____

Sleep pattern details:

_____

_____

GENERAL HEALTH

__Fatigue
__Fevers
__Chills
__Night sweats
__Excessive thirst
__Sudden energy drops
__Slow metabolism
__Intolerance to heat/cold

Is there anything else you would like to mention not previously listed?

_____

_____

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