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Idaho Nutrition & Wellness Clinic

**Health History Intake**

1. What are your primary health concerns? List in order of importance.

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1. Relationship Status?

* Single
* Married
* Separated
* Divorced
* Widowed

1. With whom do you live?

* Spouse
* Family
* Friends
* Children
* Alone

1. Do you have children?

* Yes How many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* No

1. Current Height? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Primary interests and hobbies?

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1. Primary form of exercise? How often?

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Any Family History of Diabetes, Heart Disease, High Blood Pressure, Stroke, Mental Illness, Allergies and/or Cancer? If yes, please list family member and disease.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What hospitalizations and surgeries have you had? Please include details and dates.

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1. Please list all prescription medications, over the counter medications, vitamins, or any other supplement you are taking?

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1. Check each that you currently use?

* Laxatives
* Pain Relievers
* H2 blockers/ulcer medication
* Antacids
* Antibiotics
* Cortisone/Prednisone
* Appetite Suppressants
* Antidepressants
* Thyroid medications
* Cholesterol lowering medication
* Sleeping medication
* Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Symptoms: Please indicate and circle which symptoms you currently have now (Y) in the past (P) or Never (N).**

**Skin Head**

Rashes Y P N Headache Y P N

Eczema Y P N Migraines Y P N

Acne Y P N Head Injury Y P N

Itching Y P N Dandruff Y P N

Color change Y P N

Hair Loss Y P N

**Eyes Ears**

Impaired Vision Y P N Impaired Hearing Y P N

Glasses/Contacts Y P N Ringing/Noises in Ears Y P N

Eye Pain Y P N Earache Y P N

Tearing or Dryness Y P N Dizziness Y P N

Redness Y P N Itching in Ears Y P N

Double Vision Y P N

Glaucoma Y P N **Respiratory**

Cataracts Y P N Cough Y P N

Aversion to Sun Y P N Spitting up Mucus Y P N

Sties Y P N Spitting up Blood Y P N

Wheezing Y P N

**Mouth,Throat, Neck** Asthma Y P N

Frequent sore throat Y P N Bronchitis Y P N

Gum problems Y P N Pneumonia Y P N

Hoarseness Y P N Pleurisy Y P N

Canker Sores Y P N Emphysema Y P N

Swollen Glands Y P N Difficulty breathing Y P N

Goiter Y P N Pain with breathing Y P N

Difficulty Climbing Stairs Y P N

**Cardiovascular**

Heart Disease Y P N **Gastrointestinal**

Angina Y P N Trouble Swallowing Y P N

High blood pressure Y P N Heartburn Y P N

Murmurs Y P N Change in thirst Y P N

Rheumatic fever Y P N Change in appetite Y P N

Chest pain Y P N Nausea Y P N

Swelling in Ankles Y P N Vomiting Y P N

Palpitations, Fluttering Y P N Constipation Y P N

Bloating Y P N

**Nose and Sinuses** Blood in stool Y P N

Frequent colds Y P N Diarrhea Y P N

Sinus problems Y P N Passing Gas Y P N

Nose bleeds Y P N Gall Bladder Disease Y P N

Stuffiness Y P N Liver Disease Y P N

Loss of smell Y P N Hemorrhoids Y P N

Frequent sneezing Y P N Abdominal stomach pain Y P N

Hay fever Y P N Ulcer Y P N

# bowl movements per day\_\_\_\_\_\_\_\_

**Urinary Male Reproductive**

Pain with urination Y P N Hernias Y P N

Increased frequency Y P N Testicular Masses Y P N

Frequency at night Y P N Testicular Pain Y P N

Inability to hold urine Y P N Sexual Difficulties Y P N

Frequent infections Y P N Prostrate Disease Y P N

Kidney stones Y P N Sexually transmitted disease Y P N

Discharge or sores Y P N

**Sexual Preference**

* Heterosexual
* Homosexual
* Bisexual

**Female Reproductive Musculoskeletal**

Bleeding between periods Y P N Joint pain or stiffness Y P N

Irregular cycles Y P N Arthritis Y P N

Painful menses Y P N Broken Bones Y P N

Excessive flow Y P N Muscle Spasms/ cramps Y P N

PMS Y P N Weakness Y P N

Abnormal pap smear Y P N

Birth control Y P N **Peripheral Vascular**

Difficulty conceiving Y P N Deep Leg Pain Y P N

Menopausal symptoms Y P N Cold hands/feet Y P N

Uterine fibroids Y P N Varicose Veins Y P N

Endometriosis Y P N Thrombophlebitis Y P N

Ovarian cysts Y P N

Sexual difficulties Y P N **Neurologic**

Pain during intercourse Y P N Seizures Y P N

Sexually transmitted disease Y P N Paralysis Y P N

Breast lumps Y P N Muscle Weakness Y P N

Breast pain or tenderness Y P N Numbness/Tingling Y P N

Nipple discharge Y P N Loss of memory Y P N

Age Menses began \_\_\_\_\_\_\_\_\_ Loss of Balance Y P N

Average # of days

bleeding during cycle \_\_\_\_\_\_\_\_\_\_

Number of pregnancies \_\_\_\_\_\_\_\_\_

Number of live births \_\_\_\_\_\_\_\_\_

Number of miscarriages \_\_\_\_\_\_\_\_\_

Number of abortions \_\_\_\_\_\_\_\_\_\_

Do you do self-breast exams? Yes No

**Mental Emotional Endocrine**

Treated for Emotional Problems Y P N Hypo/Hyper Thyroid Y P N

Depression Y P N Heat/Cold Intolerance Y P N

Considered/Attempted Suicide Y P N Excessive thirst Y P N

Poor concentration Y P N Excessive hunger Y P N

Increased irritability Y P N Hypoglycemia Y P N

Mood swings Y P N Fatigue Y P N

Anxiety, nervousness Y P N Diabetes Y P N

**Sleep**

Difficulty falling asleep Y P N **Blood**

Interrupted sleep Y P N Anemia Y P N

Feel rested in morning Y P N Easy bruising/bleeding Y P N

Average hours of sleep per night\_\_\_\_\_\_\_\_\_\_\_\_ Blood clots Y P N

**Lifestyle Habits (mark all that apply)**

* Average 6-8 hours of sleep
* Sleep well
* Awake rested
* Have a supportive relationship
* History of abuse
* Major traumas
* Use recreational drugs
* Treated for drug dependence
* Drink coffee
* Drink tea
* Drink cola or other sodas
* Use artificial sweetener
* Enjoy work
* Take vacations
* Spend time outside, # of hours\_\_\_\_\_\_\_\_\_\_\_
* Watch TV, # of hours\_\_\_\_\_\_\_\_\_\_\_
* Read
* Drink alcohol, # of drinks per day\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # per week\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Use tobacco currently, how much?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Used tobacco in the past, how long and how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have a religious/spiritual practice

**I certify that the information that I have supplied is correct and accurate to the best of my knowledge. I also promise to update my health history with Idaho Nutrition & Wellness Clinic upon new diagnoses and or major changes regarding my health.**

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_