

# HEALTH HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_ Number of Children \_\_\_\_\_

Marital Status:  Single  Partner  Married  Separated  Divorced  Widow(er)

Are you recovering from a cold or flu? \_\_\_\_\_ Are you pregnant? \_\_\_\_\_

Reason for office visit: \_\_\_\_\_ Date began: \_\_\_\_\_

Date of last physical exam \_\_\_\_\_ Practitioner name and phone number \_\_\_\_\_

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): \_\_\_\_\_

Outcome \_\_\_\_\_

What types of therapy have you tried for this problem(s):  
 diet modification  fasting  vitamins/minerals  herbs  homeopathy  chiropractic  acupuncture  conventional drugs  
 other \_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_

Current medications (prescription or over-the-counter): \_\_\_\_\_

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): \_\_\_\_\_

Do you consider yourself:  underweight  overweight  just right Your weight today \_\_\_\_\_

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? \_\_\_\_\_

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)? \_\_\_\_\_

Corrective lenses  Dentures  Hearing aid  Medical devices/prosthetics/implants, describe: \_\_\_\_\_

Recent changes in your ability to:  see  hear  taste  smell  feel hot/cold sensations  
 move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors:  sour  bitter  sweet  rich/fatty  spicy/pungent  salty

Strong dislike for any one of the following flavors:  sour  bitter  sweet  rich/fatty  spicy/pungent  salty

Do you:  Prefer warmth (i.e., food, drinks, weather, etc.)  Prefer cold (i.e., food, drinks, weather, etc.)  No preference

Is your sleep disturbed at the same time each night? \_\_\_\_\_ If yes, what time? \_\_\_\_\_

Time of day you feel the most energy or the least symptoms: \_\_\_\_\_ Time of day you feel the worst or your symptoms are aggravated: \_\_\_\_\_

<input type="checkbox"/> 7 a.m. - 9 a.m.	<input type="checkbox"/> 9 a.m. - 11 a.m.	<input type="checkbox"/> 11 a.m. - 1 p.m.	<input type="checkbox"/> 7 a.m. - 9 a.m.	<input type="checkbox"/> 9 a.m. - 11 a.m.	<input type="checkbox"/> 11 a.m. - 1 p.m.
<input type="checkbox"/> 1 p.m. - 3 p.m.	<input type="checkbox"/> 3 p.m. - 5 p.m.	<input type="checkbox"/> 5 p.m. - 7 p.m.	<input type="checkbox"/> 1 p.m. - 3 p.m.	<input type="checkbox"/> 3 p.m. - 5 p.m.	<input type="checkbox"/> 5 p.m. - 7 p.m.
<input type="checkbox"/> 7 p.m. - 9 p.m.	<input type="checkbox"/> 9 p.m. - 11 p.m.	<input type="checkbox"/> 11 p.m. - 1 a.m.	<input type="checkbox"/> 7 p.m. - 9 p.m.	<input type="checkbox"/> 9 p.m. - 11 p.m.	<input type="checkbox"/> 11 p.m. - 1 a.m.
<input type="checkbox"/> 1 a.m. - 3 a.m.	<input type="checkbox"/> 3 a.m. - 5 a.m.	<input type="checkbox"/> 5 a.m. - 7 a.m.	<input type="checkbox"/> 1 a.m. - 3 a.m.	<input type="checkbox"/> 3 a.m. - 5 a.m.	<input type="checkbox"/> 5 a.m. - 7 a.m.

**Do you experience any of these general symptoms EVERY DAY?**

<input type="checkbox"/> Debilitating fatigue	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Insomnic	<input type="checkbox"/> Constipation	<input type="checkbox"/> Chronic pain/inflammation
<input type="checkbox"/> Depression	<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Nausea	<input type="checkbox"/> Fecal incontinence	<input type="checkbox"/> Bleeding
<input type="checkbox"/> Disinterest in sex	<input type="checkbox"/> Headaches	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Urinary incontinence	<input type="checkbox"/> Discharge
<input type="checkbox"/> Disinterest in eating	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Low grade fever	<input type="checkbox"/> Itching/rash

## Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_

## Medical (Men)

- Benign prostatic hyperplasia (BPH)
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other \_\_\_\_\_

## Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date of last gynecological exam \_\_\_\_\_
- Mammogram  +  -
- PAP  +  -
- Form of birth control \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- C-section
- Surgical menopause
- Menopause
- Date of last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Interval of time between cycles \_\_\_\_\_ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) \_\_\_\_\_

## Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other \_\_\_\_\_

## Health Habits

- Tobacco:  
Cigarettes: #/day \_\_\_\_\_  
Cigars: #/day \_\_\_\_\_
- Alcohol:  
Wine: #glasses/d or wk \_\_\_\_\_  
Liquor: #ounces/d or wk \_\_\_\_\_  
Beer: #glasses/d or wk \_\_\_\_\_
- Caffeine:  
Coffee: #6 oz cups/d \_\_\_\_\_  
Tea: #6 oz cups/d \_\_\_\_\_  
Soda w/caffeine: #cans/d \_\_\_\_\_  
Other sources \_\_\_\_\_
- Water: #glasses/d \_\_\_\_\_

## Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk
- Run, jog, jump rope
- Weight lift
- Swim
- Box
- Yoga

## Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:  
 dairy  wheat  eggs  
 soy  corn  all gluten
- Other \_\_\_\_\_

## Food Frequency

- Servings per day:  
Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow/orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy, eggs \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

## Eating Habits

- Skip breakfast
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

## Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals, describe \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs - teas
- Herbs - extracts
- Chinese herbs
- Ayurvedic herbs
- Homeopathy
- Bach flowers
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals
- Other \_\_\_\_\_

## Would you like to:

- Have more energy
- Be stronger
- Have more endurance
- Increase your sex drive
- Be thinner
- Be more muscular
- Improve your complexion
- Have stronger nails
- Have healthier hair
- Be less moody
- Be less depressed
- Be less indecisive
- Feel more motivated
- Be more organized
- Think more clearly and be more focused
- Improve memory
- Do better on tests in school
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives or stool softeners
- Be free of pain
- Sleep better
- Have agreeable breath
- Have agreeable body odor
- Have stronger teeth
- Get less colds and flus
- Get rid of your allergies
- Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)