HEALTH HISTORY

Name:	**Date of birth:**
Reason for Visit:	

Please list all major illnesses, surgeries, emotional traumas, etc.
Please list issues of concern you but have been brushed aside by healthcare practitioners.

Pre-term to birth to 1yo:	19yo to 29yo:
2yo to 5yo (pre school)	30yo to 39yo:
6yo to 9 yr (grade school)	40yo to 49yo:
10 yr to 12 yr (middle school)	50yo to 60yo:
13 to 18yo (high school)	60yo and older:
OCCUPATION:	HIGHEST LEVEL OF EDUCATION:

Please indicate the approximate year (or date) of your last:

Complete physical exam:	**Cardiovascular Evaluation**
Gastrointestinal evaluation:	EKG
Upper GI (endoscopy)	Echocardiogram
Lower GI (colonoscopy)	Stress test
Ultrasound	**Xrays - Imaging**
Thyroid	CT scan
Pelvis	MRI
Gall bladder	Chest Xray
Abdomen	Mammogram
Other	Other

VACCINE HISTORY - **CIRCLE ALL THAT APPLY**

DTaP		HiB	Flu shot	Gardasil	Typhoid	RhoGam
MMR		Prevnar	Flu Mist	Meningitis (college)	Cholera	
Polio		Rotavirus	Flu shot: H1N1	Tetanus booster	Yellow Fever	
Hepatitis A			Flu Mist (nasal)		Smallpox	
Hepatitis B					Anthrax	

FAMILY HEALTH HISTORY

	GOOD	POOR	DECEASED	AGE DECEASED	MEDICAL- HEALTH PROBLEMS
Father					
Mother					
Sister (s)					
Brothers (s)					

Signature: **Today's Date:**

PHYSICAL HISTORY - SYMPTOMS

Please put an X next to all symptoms you are currently experiencing.

GENERAL COMPLAINTS		GASTROINTESTINAL		MENTAL - EMOTIONAL		MUSCULOSKELETAL	
Alcohol problems		Abdominal pain		ADD		Ankle pain	
Drug addiction		Alt diarrhea/constipation (IBS)		ADHD		Foot pain	
Cancer - current. Type?		Always hungry		Anorexia		Headaches - cluster	
		Bloating		Bulimia		Headaches - migraine	
Cancer - past. Type?		Blood/black stools		Chronic anxiety		Headaches - tension	
		Burping to excess		Compulsive behavior		Hip pain	
THYROID		Constipation		Depression		Knee pain	
Constipation		Daily diarrhea		Excessive fatigue		Low back pain	
Dry hair		Excessive gas		Excessive irritability		Neck pain	
Dry skin		GERD or reflux		Insomnia		Shoulder pain	
Feel cold		Hemorrhoids		Nervousness		Osteoarthritis	
Goiter		Jaundice		Poor memory		Osteopenia	
Hair loss		Pain after eating		Sleep difficulties		Osteoporosis	
High cholesterol		Stomach pain after eating				Rheumatoid arthritis	
Hyperthyroid diagnosis							
Hypothyroid diagnosis		**RESPIRATORY - LUNGS**		**NEUROLOGICAL**		**URINARY - REPRODUCTIVE**	
Unexplained wt gain		Asthma		History of Concussions		**MEN**	
		Recurent sinus infections		History of stroke		Difficulty urinating	
CARDIOVASCULAR		Hay fever/seasonal allergies		Lightheaded - continual		Elevated PSA level: _______	
Ankle swelling		Frequent colds		Lightheaded - periodical		Enlarged prostate	
Cannot sleep lying flat		Emphysema		Neuropathy - feet		Erectile dysfunction	
Chest pain with activity		COPD		Neuropathy - other		Incontinence	
Heart murmur		Chronic bronchitis		Vertigo - room spins		Kidney stones	
High blood pressure						Testicular pain	
High cholesterol		**DENTAL HISTORY**		**SKIN PROBLEMS**		**WOMEN**	
High triglycerides		Braces		Dermagraphia		Bleeding after intercourse	
Leg cramps with walking		Jaw locking/popping		Eczema		Irregular menses cycle	
Palpitations		TMJ pain		Hives - chronic		Painful intercourse	
		Extractions		Hives - occasional		PMS symptoms	
		Dentures		Psoriasis		Urinary incontinence	
		Wear day time mouth guard?		Rashes		Vaginal dryness	
		Wear night time mouth guard?		Sun sensitivity		Number of pregnancies: ___	
						Age first menses:_____	
						Date last pap:_____	
						Date last mammogram:___	
						Date last thermogram: ___	

Past medical history - more than 6 months ago

Blood clots		Other:					
Blood transfusion		Other:					
Cancer		Other:					
Diverticulitis		Other:					
Heart attack							

Past surgical history

What type of surgery?		DATES					

ANYTHING ELSE YOU WOULD LIKE US TO KNOW?

Signature: **Today's Date:**

MEDICATION HISTORY

Please list all of the prescription medications you are CURRENTLY taking, and the dosage strength. If you are taking a generic medication, please include the common name, (ex: Fluoxitine is **Paxil**; ex: Omeprazole is **Prilosec**).

	Medication name (generic)	**Medication name (common)**	**Dosage Strength**	**# times/day**	**OVER THE COUNTER MEDICATIONS**	**Dosage Strength**	**# times/day**	**MEDICATIONS YOU HAVE TAKEN IN THE PAST (NAMES ONLY)**
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								

SUPPLEMENTS YOU ARE CURRENTLY TAKING

	Supplement		**Dosage Strength**	**# times/day**	**Supplement**	**Dosage Strength**	**# times/day**

DRUG, SUPPLEMENT, FOOD AND ENVIRONMENTAL ALLERGIES/INTOLERANCES

	MEDICATIONS ALLERGY	**SUPPLEMENT ALLERGY**
1		
2		
3		
4		
5		
6		
7		
8		

ENVIRONMENTAL ALLERGIES

Dogs	Grass	Smoke	Dairy	Rabbits	Mold	Other:
Cats	Spring pollen	Perfumes	Wheat	Guinea pigs	Sugars	
Birds	Fall pollen	Chemicals	Corn	Rag Weed	Food dyes	Other:
Horses	Dust		Fructose	Poison Ivy		

Signature:	**Today's Date:**

NUTRITION HISTORY

How often do you consume the following foods?

1 = Daily		2 = 3-4 times/week		3 = Occasionally		4 = Never	
Alcohol - liquor		Wheat/gluten		Eggs		Fast food	
Alcohol - wine		Non-gluten grains		Red meat		Restaurant food	
Coffee - regular		White rice		Chicken		Pkg/proc food	
Coffee - decaf		Brown rice		Fish		White flour	
Black Tea		Cheese		Pork		White sugar	
Green Tea		Milk - cows milk		Beans		Canned Fruit	
Other types of tea		Yogert		Fresh fruit		Frozen fruit	
Soda pop		Butter		Fresh veggies		Frozen veggies	
		Margarine					

What do you crave to eat?

What diets have you tried before? (ex: Weight Watchers, Physician Weight Loss, HCG, etc)

Were you successful in losing weight? If so, were you able to keep the weight off? Why or Why not?

List typical daily diet:

BREAKFAST	LUNCH	DINNER	SNACKS

Signature: **Today's Date:**

SLEEP - ENERGY HISTORY

What time of day are your symptoms worse?					S T O P	B A N G	SCORE-->		(by your practitioner) score of 4 or more is significant
Morning	Afternoon	Evening	Bad all day long						

What makes your symptoms better?

The **Epworth Sleepiness Scale** is used to determine your daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy and significant, indicating the need for either more sleep, better sleep hygiene, and/or a screening test for sleep apnea.

What makes your symptoms worse?

0 = would never doze or sleep		**3 = moderate chance I would doze or sleep**	
1 = slight chance I would doze or fall asleep		**4 = high chance I would doze or sleep**	

How would you describe your sleep patterns?		Sitting and reading			
	I sleep well and wake up rarely during the night.	Watching TV			
	I sleep well. If I get up, I return to sleep easily.	Sitting inactive in public place			
	I sleep well. But if I get up, I have difficulty falling back to sleep.	Passenger in car for > 1 hour			
	I have difficulty falling asleep, but once asleep, I sleep well.	Sitting and talking to someone			
	I fall asleep easily but I have difficulty staying asleep.	Sitting quietly after lunch			
	I wake up consistently at _______ AM several times a week.	Stopped at a traffic light while driving			
	I snore loudly and often wake my partner up.	TOTAL SCORE -->			
	Most mornings I wake up feeling exhausted and feel like I barely slept at all.	**On scale of 1 to 10, what is your present stress level?**			
	I often wake up with a headache.	TOTAL SCORE -->			

Have you been diagnosed with **sleep apnea**? If so, do you use a **CPAP** machine every night?

What has been the most significant **medica**l occurrence in your life?

What has been your most signficant **emotional** occurrence in your life?

What is your greatest **fear**?

What really makes you **happy**?

What is your favorite **relaxation time** activity?

SOCIAL HISTORY

Do you smoke?	Yes	No	If yes, how much and for how long?	Do you drink alcohol?	Yes	No	If yes, how much and for how long?
Did you quit smoking?	Yes	No	When did you stop smoking?	Have you stopped drinking alcohol?	Yes	No	When did you stop drinking?
Do you exercise regularly?	Yes	No	What type of exercise do you enjoy? How often?				

Signature: **Date:**