**HEALTH HISTORY**

Name_______________________________________________Date____________________

Occupation______________________________Age_______Height______Sex____# of Children______

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

Reason for office visit: ________________________________________________

________________________________________________

________________________________________________

________________________________________________

List current health problems for which you are being treated: ______________________

________________________________________________

________________________________________________

________________________________________________

What types of therapies have you tried for these problem(s) or to improve your health overall?:

☐ Diet modification ☐ Fasting ☐ Vitamins/minerals ☐Herbs ☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs

Do you experience any of these general symptoms EVERY DAY?

| | | | | |
|---|---|---|---|---|
| ☐ Debilitating fatigue | ☐ Shortness of breath | ☐ Insomnia | ☐ Constipation | ☐ Chronic pain/inflammation |
| ☐ Depression | ☐ Panic attacks | ☐ Nausea | ☐ Fecal incontinence | ☐ Bleeding |
| ☐ Disinterest in sex | ☐ Headaches | ☐ Vomiting | ☐ Urinary incontinence | ☐ Discharge |
| ☐ Disinterest in eating | ☐ Dizziness | ☐ Diarrhea | ☐ Low grade fever | ☐ Itching/rash |

Current medications (prescription or over-the counter): ______________________

________________________________________________

________________________________________________

________________________________________________

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

________________________________________________

Outcome ________________________________________________

________________________________________________

________________________________________________

________________________________________________

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 is the lowest) 1 2 3 4 5 6 7 8 9 10

Identify major causes of stress (e.g., changes in job, work, residence, 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 (i.e., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.?) ________________________________________________

________________________________________________

What are your current health goals?: ________________________________________________

________________________________________________

________________________________________________

________________________________________________

________________________________________________

________________________________________________

## 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, elevate
- ☐ 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 of gallbladder disease ( stones)
- ☐ Mental illness
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other____________________

**MEDICAL (MEN)**

- ☐ Benign prostatic hyperplasia
- ☐ Prostrate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease
- ☐ Other ____________________

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**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 ____________________

Date of last GYN exam ________

Mammogram ☐ + ☐ –

Pap ☐ + ☐ –

Form of birth control ___________

# of children _________________

# of pregnancies _______________

☐ C-section

Age of first period _____________

Date – 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)____________

- ☐ Surgical menopause
- ☐ Menopause

**FAMILY HEALTH HISTORY**

(Parents & 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: #/glasses 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 mins duration per workout
- ☐ 30-45 mins duration per workout
- ☐ Less than 30 minutes
- ☐ Walk: #/days wk____________
- ☐ Run, jog, other aerobic - #days/wk__________________
- ☐ Weight lift - #days/wk________
- ☐ Stretch - #days/wk___________
- ☐ Other______________________

**NUTRITION & DIET**

- ☐ Mixed food diet (animal & vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

☐ dairy ☐ wheat ☐ eggs

☐ soy ☐ corn ☐ all gluten

Other______________________

**FOOD FREQUENCY**

Number of 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 meals (which ones)______

___________________________

- ☐ One meal a day
- ☐ Two meals a day
- ☐ Three meals a day
- ☐ Graze (small, frequent meals)
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not

## 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
- ☐ Homeopathy
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals (Ensure)
- ☐ Others_____________________

**I WOULD LIKE TO**

**<u>ENERGY/VITALITY</u>**

- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be less tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the Counter medications like aspirin, ibuprofen, anti-histamines, sleep aids, etc.
- ☐ Stop using laxatives and stool softeners
- ☐ Improve sex drive

**BODY COMPOSITION**

- ☐ Lose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

**STRESS, MENTAL, EMOTIONAL**

- ☐ Learn how to reduce stress
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Feel more motivated

**LIFE ENRICHMENT**

- ☐ Reduce risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from "treating illness" to a wellness lifestyle