Health History

Name	Today's Date

Age	Date of Birth	Height	Weight

Please indicate if you have any of the following:

☐ Cardiac pacemaker ☐ Seizure disorder
☐ Bleeding disorder ☐ Fainting Disorder
☐ Believe you are or may be pregnant ☐ HIV
☐ Hepatitis B ☐ Surgical implant; what kind?_____

Chief Complaint

_____

List any current therapies or treatments	List all current prescription medications
_____	_____
_____	_____
_____	_____

Hospitalizations and Surgeries (specify reason and date)

Social History – please check applicable boxes bellow and fill in accurate amount of standard portions

Physical Work
☐ Heavy ☐ Light
☐ Moderate ☐ None
Hours per day _____

Mental Work
☐ Heavy ☐ Light
☐ Moderate ☐ None
Hours per day _____

Exercise
☐ Heavy ☐ Light
☐ Moderate ☐ None
Hours / Week _____
Type _____

Meals
☐ 3 Meals a Day
☐ _____ a Day

Sleep
_____ Hours / Night
Wake Up Rested? ☐ Yes ☐ No

Nutritional Information
☐ Low Sodium Diet ☐ Diabetic Diet
☐ Low Fat Diet ☐ Vegetarian Diet
☐ Low Cholesterol Diet
☐ Other_____

Aspirin
☐ None
No. / Day _____
No. of Yrs. _____
Other _____

Caffeine
☐ None ☐ Coffee
☐ Tea ☐ Cola
☐ Other _____
Cups / Day _____
No. Yrs. _____

Alcohol
☐ Beer / Week _____
☐ Liquor / Week ____
☐ Wine / Week _____
☐ None
No. of Years _____

Smoking
☐ None ☐ Previous
☐ Current
No. of Yrs. _____
Quit Yr. _____

Miscellaneous Drugs
☐ Vitamins ☐ Herbs ☐ Laxatives
☐ Antacids ☐ Pain Pills ☐ Diet Pills
☐ Sleeping Pills ☐ Saccharin ☐ NutraSweet
☐ Marijuana ☐ Cocaine ☐ Amphetamines
☐ Others _____

Have you experienced any major emotional/ physical trauma?	**Allergies**

Family History – please check applicable boxes below and indicate family member (father, mother, brother, sister, spouse, child)

☐ Cancer _____ ☐ Diabetes _____ ☐ Heart Disease _____
☐ High Blood Pressure _____ ☐ Stroke _____ ☐ Mental Illness _____
☐ Asthma _____ ☐ Hay fever / Hives _____ ☐ Kidney Disease _____

Review Symptoms – check only the one you **now** have or have had **recently**

Emotional
☐ Mood Swings ☐ Nervousness ☐ Mental Tension ☐ Hyperventilation

Energy and Immunity
☐ Slow Wound Healing ☐ Chronic Infection ☐ Chronic Fatigue Syndrome

Patient's name	Today's Date

Review Symptoms – check only the one you **now** have or have had **recently**

Skin
☐ Color Change ☐ Rashes ☐ Itching ☐ Eczema / Hives ☐ Sores ☐ Dryness

Head
☐ Headaches ☐ Injuries ☐ Bumps

Eyes
☐ Redness ☐ Pain / Strain ☐ Dryness ☐ Burning
☐ Swelling ☐ Itching ☐ Tearing ☐ Blurred Vision
☐ Glasses / Contacts ☐ Glaucoma

Ears
☐ Hearing Loss ☐ Ringing ☐ Discharge ☐ Earache
☐ Itching ☐ Loss of Balance ☐ Dizziness ☐ Spins

Nose
☐ Decreased Smell ☐ Bleeding ☐ Pain ☐ Discharge ☐ Obstruction
☐ Postal Nasal Drip ☐ Deviated Septum ☐ Runny Nose ☐ Nasal Congestion ☐ Sinus Congestion
☐ Snoring

Mouth
☐ Bleeding Gums ☐ Sores ☐ Dental Problems ☐ Pain
☐ Bad Breath ☐ Loss of Taste ☐ Dryness ☐ Ulcers / Blisters
☐ TMJ / Jaw Problems

Throat
☐ Frequent Sore Throat ☐ Hoarseness ☐ Pain ☐ Hard to Swallow ☐ Recurrent Infections

Neck
☐ Enlargement ☐ Stiffness ☐ Soreness ☐ Lumps ☐ Masses

Respiratory
☐ Persistent Chough ☐ Shortness of Breath ☐ Asthma ☐ Tuberculosis
☐ Phlegm ☐ Difficulty Breathing ☐Emphysema ☐ Pneumonia
☐ Frequent Common Colds ☐ Coughed Blood ☐ Inhalant Exposure

Cardiovascular
☐ Heart Disease ☐ Varicose Veins ☐ Chest Pain ☐ High Blood Pressure
☐ Palpitations / Fluttering ☐ Swollen Extremities ☐ Stroke ☐ Heart Murmurs
☐ Rapid Heartbeat ☐ Rheumatic Fever ☐ Blood Clots

Gastrointestinal
☐ Ulcers ☐ Changes in Appetite ☐ Passing Gas ☐ Nausea / Vomiting
☐ Epigastric Pain ☐ Heartburn ☐ Belching ☐ Indigestion
☐ Liver / Gallbladder Disease ☐ Hepatitis B or C ☐ Hemorrhoids ☐ Abdominal Pain

Urological
☐ Kidney Disease ☐ Frequent Urination at Night ☐ Blood in Urine ☐ Painful Urination
☐ Frequent Urination ☐ Frequent Urinary Tract Infection ☐ Kidney Stones
☐ Difficult Urination

Musculoskeletal
☐ Neck / Shoulder Pain ☐Mid Back Pain ☐ Upper Back Pain ☐ Lower Back Pain
☐ Muscle Spasm / Cramps ☐ Arm Pain ☐ Leg Pain ☐ Joint Pain

Neurological
☐ Vertigo / Dizziness ☐ Seizures / Epilepsy ☐ Paralysis ☐ Numbness / Tingling ☐ Loss of Balance

Endocrine
☐ Hypothyroid ☐ Hyperthyroid ☐Hypoglycemia
☐ Diabetes Mellitus ☐ Feeling Hot or Cold ☐ Night Sweats

Other
☐ Anemia ☐ Cold Hands / Feet ☐ Cancer

Patient's Name	Today's Date

Review Symptoms – check only the one you **now** have or have had **recently**

Female Reproduction

Libido (Sex Drive)

☐ Normal ☐ Low ☐ High

Breasts

☐ Lumps ☐ Tenderness ☐ Engorged / Painful Before Menses ☐ Nipple Discharge

Menstruation / Birthing History

☐ Bleeding Between Cycles ☐ Irregular Cycles ☐ Painful Menstruation ☐ Heavy Menstruation
☐ Vaginal Discharge ☐ Premenstrual ☐ Clotting ☐ Difficulty Conceiving
☐ Menopausal Symptoms ☐ Mood Changes ☐ Nausea ☐ Diarrhea / Constipation Before or During Menses

Menstrual Flow ☐ Normal ☐ Heavy ☐ Light

Color of Flow ☐ Bright Red ☐ Dark Red ☐ Purple ☐ Light Brown ☐Brown

Age of 1st menses:_____ # of days of menses:_____ # of miscarriages: _____
Birth control type:_____ # of live births:_____
Length of cycle:_____ # of pregnancies:_____

Male Reproduction

Libido (Sex Drive)

☐ Normal ☐ Low ☐ High

☐ Feeling of Coldness or Numbness in External Genitalia ☐ Enlarged Prostate ☐ Erectile Dysfunction / Impotence ☐ Penile Discharge ☐ Low Sperm Count ☐ Testicular Pain or Swelling

Please list below any other symptoms or concerns that you may have