Health History

Date			**Phone**		
Name			**Social Security No.**		
email				**Date of Birth**	
Address					
Height			**Weight**		
Allergies/medication sensitivities/reactions					
Current Medications - Prescription & Non-prescription (name & dose)					
Current Supplements (name & dose)					
Current Medical Problems					
Hospital Admissions/Surgeries & Date					
Screening Tests					
Test	Date	Result	Test	Date	Result
Mammogram			Rectal Exam		
Thermography			PSA		
Pap Smear			Colonoscopy		
Bone Density			Eye Exam		
Blood Sugar			Skin Exam		
Lipids/Cholesterol			Dental Exam		
Immunizations					
Immunizations		Year	Immunizations		Year
Tetanus			Hepatitis		
Influenza			Pneumonia		
H1N1			HPV		

Family History

please circle and indicate which relative(s)

1. Hypertension	2 .Heart disease	3. Stroke	4. Blood clots
5. Anemia	6. Bleeding disorders	7. Lipid disorders	8.Alcohol/Drug abuse
9.Osteoporo./fracture	10. Asthma	11. Arthritis	12. thyroid disease
13. Alzheimers/Dementia	14. Mental illness	15. Epilepsy	16. Diabetes
17. Cancer	18. Glaucoma	19. Hay fever	20. Hepatitis
Details:			

Loss of loved ones:

Medical History

Enter 'X' and indicate age or date for all questions which have ever applied to you
Enter 'C' for current ongoing problems and give date and details

	Dizzy spells		Loss of appetite-recent
	Fainting spells		Difficulty swallowing
	Double/blurred vision		Heart burn
	Eye pain		Peptic ulcer
	Ear infections-frequent		Persistent nausea/vomiting
	Decreased hearing		Abdominal pain-chronic
	Ringing in ears		Gall bladder trouble
	Nose bleeds-frequent		Jaundice/Hepatitis
	Sinus problems		Bowel movement___times/day
	Hoarseness		Bowel movement___times/week
	Sore throats-frequent		Frequent constipation
	Dental problems		Frequent diarrhea
	Floss teeth ___ times per week		Bloody/tarry stools
	Allergies/Hay fever		Diverticulosis
	Pneumonia/Pleurisy		Colitis/Crohn's
	Bronchitis/chronic cough		Hemorrhoids
	Shortness of breath:		Hernia, type
	on exertion		Urination: overactive bladder
	lying flat		Overnight>than twice
	Asthma?Wheezing		More than 8 times/24 hours
	Chest pain		Urgency to urinate
	High blood pressure		Dcreasee in urine flow/force
	Heart murmur		Painful urination
	Swollen ankles		Sexually transmitted diseases:
	Irregular pulse		Gonorrhea
	Palpitations		Syphillis
	Leg pain when walking		Chlamydia
	Varicose veins/Phlebitis		Herpes
	Cold numb feet		HPV
	Anemia		Diabetes
	Bruise easily		Thyroid disease
	Blood transfusions		Seizures
	Cancer, type:		Recent weight gain____lbs
	Chronic fatigue		Recent weight loss____lbs

	Bone fracture/ joint injury		Back pain - recurrent
	Fractures after age 50?		Caffeinated drinks_____/day
	Osteoporosis		Alcohol:
	Gout		__never __rare __weekly __daily
	Rashes		___beer ___wine ___liquor # drinks___
	Psoriasis		Felt need to stop drinking __yes __no
	Eczema		Smoking: __cigarettes or cigars/day __# yrs
	Sleeping difficulty		Year quit smoking:
	Depression		Recreational drugs
	Nervousness/ Agitation		Abuse: __physical __sexual __other
	Memory loss		Hair loss: __progressive __recent
	Moodiness		Lack of energy
	Suicidal thoughts		Lack of strength/endurance
	Anxiety/Phobias		Loss of height: ___ inches
	Mental illness		Decreased enjoyment of life
	Feelings of worthlessness		Are you sad and/or grumpy?
	Rheumatic fever		Decline in ability to do exercise/play sports
	Polio		Decline in work performance
	Tuberculosis		Falling asleep after dinner
	Herpes ___mouth ___genital		Decrease in libido
	AIDS/HIV		Satisfied with orgasm frequency/intensity
	Stroke/Mini strokes		Sexual activity: Past Current
	Tremors/shaking		Opposite sex ____ ____
	Numbness/Tingling sensation		Same sex ____ ____
	Headaches - frequent/ Migraines		Single partner ____ ____
	Arthritis: location_____		Multiple partners ____ ____
Females: please complete the following			
	Age of onset of menstrual period: ____		Miscarriages: ___ Live births: ____
	If menopausal, date of last period: _____		Did you ever breast feed? Yes ___ No ___
	Date of 1st day of last period: _____		At least 1 year collectively? Yes ___ No ___
	# days of flow: ___ length of cycle: ____days		Birth control method:
	Periods: __regular __irregular __cramps/pain		Did you ever take birth control pill?
	Pain/bleeding during/after intercourse		If yes, when and for how long?
	Pregnancies: ___ Abortions: ____		
Check symptoms you are currently experiencing			
	Mental fogginess		Increase in breast size
	Forgetfulness		Water retention
	Depression		Pelvic cramps
	Minor anxiety		Nausea
	Mood change		Flabbiness, muscular weakness
	Difficulty sleeping		Loss of hair
	Hot flashes		Lack of energy/stamina
	Night sweats		Decreased sex drive
	Dry skin and vagina		Decreased hair (axillary, pubic, body)
	Day-long fatigue		Harder to reach climax
	Lessened self-image		Sagging breasts, loss of fullness
How do you feel a few days before and during your period?			
How do you feel from the day of ovulation to the onset of period?			
Did you have mood swings, gain weight or experience an increase in breast size on birth control			
pills?			
Did you feel better after starting birth control pills?			

Males: please complete the following two sections							
Symptoms at this time				never	mild	moderate	severe
Decline in feeling of general well-being							
Sleep problems							
Increased need for sleep							
Fatigue							
Physical exhaustion, lack of vitality							
Excessive sweating							
Joint pain, muscular ache							
Irritability							
Nervousness							
Anxiety							
Depressive mood							
Decrease in muscular strength							
Decrease in beard growth							
Decreased ability/frequency to perform sex							
Decrease in morning erections							
Decrease in sexual desire/libido							
Over the past month: how often have you				never	rare	often	always
Had to urinate again less than 2 hours after urinating?							
Had sensation of not emptying bladder completely after urination?							
Stopped and started several times when you urinated?							
Found it difficult to postpone urination?							
Had a weak urinary stream?							
Had to push or strain to begin urinating?							
Had to get up to urinate during the night?							
Nutrition							
List any diets you have followed in the past 5 years:							
Exercises							
Current source of stress							
Primary health concerns							
Patient signature						**Date**	