Patient Health History

Name: ____ Date: ______/______/______
(first) (middle) (last)

Date of Birth: _______/_______/_______ Age: _______ Gender: M/F Marital status: S M D W

Address:
City: State: Zip Code

Home Ph: Cell: Work Ph:
Email:

Emergency Contact Tele #

Occupation:

Medical Doctor:

Other healthcare provider:

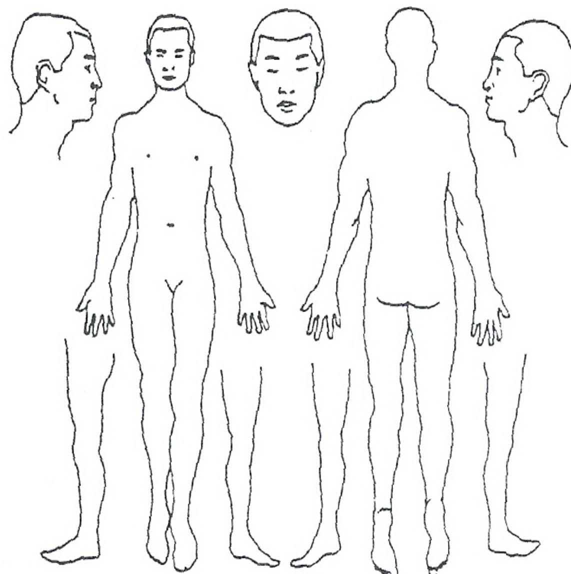
Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

1. When and where did you last receive health care? ____

For what reason? ____

2.. Please identify the health concerns that have brought you here today; List in order of most extreme.

Please indicate painful of distressed areas below



A. ____

How does this condition affect you? ___________________________

B. ____

How does this condition affect you? ___________________________

3.. List all foods, drugs, or medications you are ***hypersensitive*** or allergic to (*please include reaction*): ___________________________

____

4.. Please list any medications (prescribed and over-the-counter), vitamins, and supplements you are currently taking: ___________________________

____

____

____

5.. **Height:** __________ **Weight:** Currently: __________ Past Maximum: _________ When? __________________

6.. **Blood Pressure:** What is your most recent blood pressure reading? _______/_______ When was this reading taken? ________

7.. **Immunizations** (please circle any that you have had):

Polio   Tetanus   Rubella/Mumps/Rubella   Pertussis   Diphtheria   Hib   Hepatitis B

Others: ____

8. **Other** (please circle any that you experience now and underline any that you have experienced in the past):

Anemia   Cancer   Rashes   Eczema/Hives   Cold Hands/Feet

9.. Please circle 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 or C

Other: ____________________

10. Is there anything else we should know? ____

____

11. **Put a check mark by the symptoms that pertain to you**

( ) cold hands / feet
( ) varicose veins
( ) fatigue
( ) feverish in the afternoon or hot flashes
( ) heat sensations in the hands, feet, chest
( ) night sweating
( ) catch cold easily
( ) sweat easily
( ) dizziness
( ) see floating black spots

( ) mood swings
( ) heart murmur
( ) high blood pressure
( ) palpitations
( ) sores on the tip of tongue
( ) anxiety / nervousness
( ) chest pain radiating to shoulder
( ) ankle swelling
( ) insomnia

( ) diarrhea alternating with constipation
( ) tight feeling in the chest
( ) bitter taste in the mouth
( ) blood shot eyes / dry eyes
( ) anger easily
( ) skin rashes
( ) headache
( ) numbness of hands and feet
( ) muscle spasms, twitching, cramping
( ) seizure / convulsions

( ) sore, cold weak knees
( ) low back pain
( ) frequent urination
( ) get up more than once a night to urinate
( ) lack of bladder control
( ) memory problems
( ) hair loss
( ) ringing in ears

( ) difficult breathing
( ) cough
( ) sinus congestion / pressure
( ) dry mouth, throat, nose or skin
( ) allergies / hay fever
( ) chronic infections
( ) asthma
( ) frequent sore throats
( ) chills with alternation fever
( ) stiff neck / shoulders

Urination is:
( ) normal color (pale yellow)
( ) clear
( ) dark yellow
( ) reddish
( ) cloudy
( ) scanty
( ) has odor
( ) burning
( ) painful
( ) difficult
( ) urgent
( ) history of urinary track infections

( ) slow healing wounds
( ) TMJ / grinding teeth
( ) shortness of breath (inhale or exhale)
( ) low appetite
( ) loose stools
( ) constipation
( ) abdominal bloating or gas after eating
( ) feeling tired after eating
( ) prolapsed organs (previously diagnosed)
( ) bruise easily
( ) general feeling of heaviness in the body
( ) mental sluggishness/ forgetfulness/exhaustion
( ) swollen hands / feet
( ) burning sensation after eating
( ) large appetite
( ) bad breath
( ) mouth sores (canker sores)
( ) bleeding, swollen painful gums
( ) heartburn / belching
( ) hemorrhoids
( ) stomach pain / stomach ulcer
( ) vomiting

Libido (sex drive) Normal -- Low -- High

<u>Men Only</u>

Please put a check mark by the symptoms that pertain to you.

( ) Feeling of coldness or numbness in the external genitalia
( ) pain of swelling of testicles
( ) premature ejaculation
( ) impotence / erectile dysfunction

<u>Women Only</u>

Please answer each question or check the appropriate response.

A Are your currently pregnant now? ( ) yes ( ) no
B Number of children:
C Number of pregnancies:
D Age of first period:
E Menstrual Cycle

Average number of days of flow:
The flow is: **normal, heavy, light**

The color is: **normal, dark, purple, light brown, brown, bright red, light red / pink**
(circle as many that apply)

Women Only (Continued)

Please answer each question or check the appropriate response.

( ) menopausal symptoms (age of menopause if applicable)
( ) Premenopausal symptoms
( ) irregular cycle
( ) vaginal discharge
( ) nipple discharge
( ) heavy flow
( ) bleeding between cycles
( ) painful periods
( ) clotting
( ) premenstrual symptoms (PMS)
( ) breast lumps / tenderness
( ) difficulty conceiving

Please include any additional information related to your menstrual cycle in the space below:

12. **Lifestyle:**

a. Do you typically eat at least three meals per day? Y N If no, how many? ___________________

b. Exercise routine: ____

c. Spiritual practice: ____

d. How many hours per night do you sleep? ________ Do you wake rested? Y N

e. Level of education completed: High School Bachelors Masters Doctorate Other

f. Occupation: ________________________________ Employer: ______________________ Hours/Week: _______

Do you enjoy work? Y/N Why/Why not? ____

g. Nicotine/Alcohol/Caffeine Use: ____

h. Have you experienced any major traumas? Y N Explain: ______________________________________

____

i. How many glasses of non-caffeinated, non-carbonated beverages do you drink per day ? _____

j. Television habits: ______________________________ Reading habits: _______________________________

k. Interests and hobbies: ____

____

____

l. If there was one thing you could do, make, or create… given all the resources you needed to succeed … what would it be / what would you do? ____

____