

Patient Health History

Name: _____
(first) (middle) (last)

Date: ____ / ____ / ____

Date of Birth: ____ / ____ / ____

Age: _____

Gender: M/F

If applicable, please list any foods, drugs, or medications you are hypersensitive or allergic to (please include reaction):

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

Height: _____ Weight: Currently: _____ Past Maximum: _____ When? _____

Indicate if you have had any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Lupus erythmatosis |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Sores that will not heal | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Sexually transmitted diseases | <input type="checkbox"/> Urinary bladder problems or infections | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Epstein Barr Virus (EBV) | <input type="checkbox"/> Unusual bleeding or discharge | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Obvious change in a wart or mole |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Peptic Ulcer |
| <input type="checkbox"/> Congenital Abnormalities | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Colitis | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Skin diseases | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia or other blood disorder |
| <input type="checkbox"/> Cardiac pacemaker | <input type="checkbox"/> Irritable bowel disease | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Surgical implants | <input type="checkbox"/> Gall stones | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Epilepsy or convulsion | <input type="checkbox"/> Tuberculosis | |
| <input type="checkbox"/> Change in bowel or bladder habits | | |

Menstrual History

1. Age of your first period:
2. Vaginal discharge:
3. Length of cycle:
4. Date of your last period:
5. Do you believe you are pregnant? Yes / No

Urology History

- Premature Ejaculation
- Impotence
- Prostate problems
- Infertility

Do you have any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Excessive bleeding | <input type="checkbox"/> Breast swelling |
| <input type="checkbox"/> Breast Pain | <input type="checkbox"/> Emotional changes with period | <input type="checkbox"/> Vaginal Yeast(Candida) infections |
| <input type="checkbox"/> Menstrual blood clots | <input type="checkbox"/> PMS | |
| <input type="checkbox"/> Breast Cysts | <input type="checkbox"/> Hot flashes | |

Is there anything else we should know? _____

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: _____

Occupational Hazards _____

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

g. Nicotine/Alcohol/Caffeine/Drug Use: _____

h. Taste: Cravings: (circle) sweet sour salty other _____

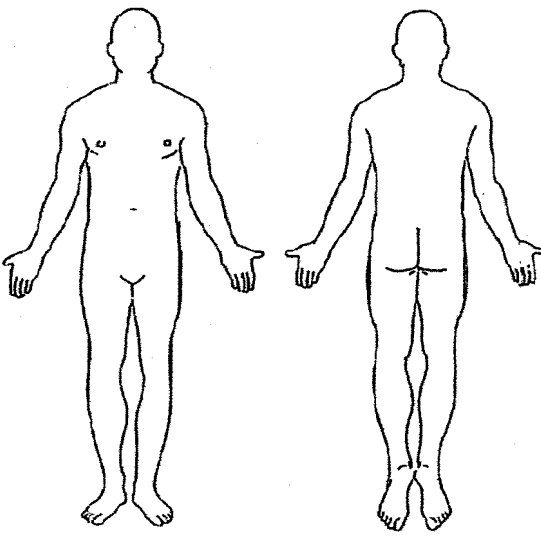
Artificial sweetener use _____

i. Have you experienced any major traumas? Y N Explain: _____

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

k. Interests and hobbies: _____

Where do you hurt? (mark):



Severity of pain (circle):
No pain 1 2 3 4 5 6 7 8 9 10 Extreme pain

Type of pain (circle all):
numb burning tingling dull/ache sharp shooting