# 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