

# HEALTH HISTORY FORM

Today's Date: \_\_\_\_\_  
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: (Home) \_\_\_\_\_ Work) \_\_\_\_\_ (Cell) \_\_\_\_\_  
Occupation: \_\_\_\_\_ Full or Part Time: \_\_\_\_\_  
Employer: \_\_\_\_\_

Email address: (if you would like to receive my monthly health e-bulletin) \_\_\_\_\_

Referred by: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

When, where and from whom did you last receive medical or health care? \_\_\_\_\_

What are your most important health concerns?

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

Which of the above problems are of most immediate concern? \_\_\_\_\_

List of current prescription medications

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Any history of allergic reaction to medications?

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List of current vitamins and supplements

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List of any other current medical or health treatments (e.g. acupuncture, massage, dental, chiropractic)

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Height \_\_\_\_\_ Weight \_\_\_\_\_

**Have you had any of the following conditions (please check)**

<u>Now</u>	<u>Past</u>		<u>Now</u>	<u>Past</u>	<u>Now</u>	<u>Past</u>	
___	___	AIDS	___	___	___	___	Meningitis
___	___	Alcohol Abuse	___	___	___	___	Mental illness
___	___	Allergies	___	___	___	___	Headaches
___	___	Anemia	___	___	___	___	
___	___	Anorexia	___	___	___	___	Obesity
___	___	Anxiety	___	___	___	___	Polio
___	___	Arthritis	___	___	___	___	Psoriasis
___	___	Asthma	___	___	___	___	ringing in ears
___	___	Bulimia	___	___	___	___	Sinus Problems
___	___	Bleeding	___	___	___	___	Stroke
___	___	Bronchitis	___	___	___	___	Swollen glands
___	___	Cancer	___	___	___	___	Syphilis
___	___	Cholera	___	___	___	___	Thyroid problems
___	___	Colitis	___	___	___	___	TMJ
___	___	Constipation	___	___	___	___	Tuberculosis
___	___	Epilepsy	___	___	___	___	Tumors
___	___	Crohn's Disease	___	___	___	___	Ulcers
___	___	Depression	___	___	___	___	Urinary problems
___	___	Diabetes	___	___	___	___	Warts

**Male reproduction**

<u>Now</u>	<u>Past</u>		<u>Now</u>	<u>Past</u>	<u>Now</u>	<u>Past</u>	
___	___	Hernias	___	___	___	___	Testicular pain
___	___	Prostate disease	___	___	___	___	Difficult erections
___	___		___	___	___	___	Testicular mass
___	___		___	___	___	___	Impotence

**Female reproduction/breasts**

Age of first menses \_\_\_\_\_ Length of cycle \_\_\_\_\_  
 Duration of menses \_\_\_\_\_ Number of pregnancies \_\_\_\_\_  
 Number of live births \_\_\_\_\_ Number of miscarriages \_\_\_\_\_  
 Number of Abortions \_\_\_\_\_ Type of birth control \_\_\_\_\_

<u>Now</u>	<u>Past</u>		<u>Now</u>	<u>Past</u>	<u>Now</u>	<u>Past</u>	
___	___	Painful menses	___	___	___	___	Abnormal PAP
___	___	Breast tenderness	___	___	___	___	Tumors
___	___	Pain during intercourse	___	___	___	___	Menopausal
___	___	Bleeding between cycles	___	___	___	___	Endometriosis
___	___	Sexual difficulties	___	___	___	___	PMS
___	___		___	___	___	___	Difficulty conceiving
___	___		___	___	___	___	Cervical dysplasia
___	___		___	___	___	___	Yeast Infections
___	___		___	___	___	___	Pelvic pain
___	___		___	___	___	___	Ovarian cysts

**Hospitalizations:**

Illnesses/inpatient or outpatient surgery \_\_\_\_\_ Date \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Check any of the following that you use. How much of each?**

___	Coffee	___	Marijuana	___	Sleeping pills
___	Tea	___	Other recreational drugs	___	Thyroid replacement
___	Cigarettes/cigars	___	Aspirin	___	Hormone replacement
___	Snuff/chewing tobacco	___	Tylenol	___	DHEA
___	Soft drinks	___	Ibuprofen	___	Chinese herbs
___	Alcohol	___	Laxatives	___	Herbs

Do you get regular exercise? \_\_\_ yes \_\_\_ no  
 If so, what kind?  
 \_\_\_\_\_

**SYMPTOM SURVEY FORM**

PATIENT \_\_\_\_\_ AGE \_\_\_\_\_ DOCTOR \_\_\_\_\_ DATE \_\_\_\_\_

INSTRUCTIONS: Number the boxes which apply to you. Use (1) for MILD symptoms (occur once or twice a month), (2) for MODERATE symptoms (occur several times a month), and (3) for SEVERE symptoms (you are aware of it almost constantly).

<b>GROUP ONE</b>		
1 <input type="checkbox"/> Acid foods upset	8 <input type="checkbox"/> Gag Easily	15 <input type="checkbox"/> Appetite reduced
2 <input type="checkbox"/> Get chilled, often	9 <input type="checkbox"/> Unable to relax, startles easily	16 <input type="checkbox"/> Cold sweats often
3 <input type="checkbox"/> "Lump" in throat	10 <input type="checkbox"/> Extremities cold, clammy	17 <input type="checkbox"/> Fever easily raised
4 <input type="checkbox"/> Dry mouth-eyes-nose	11 <input type="checkbox"/> Strong light irritates	18 <input type="checkbox"/> Neuralgia-like pains
5 <input type="checkbox"/> Pulse speeds after meal	12 <input type="checkbox"/> Urine amount reduced	19 <input type="checkbox"/> Staring, blinks little
6 <input type="checkbox"/> Keyed up - fail to calm	13 <input type="checkbox"/> Heart pounds after retiring	20 <input type="checkbox"/> Sour stomach frequent
7 <input type="checkbox"/> Cuts heal slowly	14 <input type="checkbox"/> "Nervous" stomach	
<b>GROUP TWO</b>		
21 <input type="checkbox"/> Joint stiffness after arising	29 <input type="checkbox"/> Digestion rapid	37 <input type="checkbox"/> "Slow starter"
22 <input type="checkbox"/> Muscle-leg-toe cramps at night	30 <input type="checkbox"/> Vomiting frequent	38 <input type="checkbox"/> Get "chilled" infrequently
23 <input type="checkbox"/> "Butterfly" stomach, cramps	31 <input type="checkbox"/> Hoarseness frequent	39 <input type="checkbox"/> Perspire easily
24 <input type="checkbox"/> Eyes or nose watery	32 <input type="checkbox"/> Breathing irregular	40 <input type="checkbox"/> Circulation poor, sensitive to cold
25 <input type="checkbox"/> Eyes blink often	33 <input type="checkbox"/> Pulse slow; feels "irregular"	41 <input type="checkbox"/> Subject to colds, asthma, bronchitis
26 <input type="checkbox"/> Eyelids swollen, puffy	34 <input type="checkbox"/> Gagging reflex slow	
27 <input type="checkbox"/> Indigestion soon after meals	35 <input type="checkbox"/> Difficulty swallowing	
28 <input type="checkbox"/> Always seem hungry; feels "lightheaded" often	36 <input type="checkbox"/> Constipation, diarrhea alternating	
<b>GROUP THREE</b>		
42 <input type="checkbox"/> Eat when nervous	49 <input type="checkbox"/> Heart palpitates if meals missed or delayed	53 <input type="checkbox"/> Crave candy or coffee in afternoons
43 <input type="checkbox"/> Excessive appetite	50 <input type="checkbox"/> Afternoon headaches	54 <input type="checkbox"/> Moods of depression - "blues" or melancholy
44 <input type="checkbox"/> Hungry between meals	51 <input type="checkbox"/> Overeating sweets upsets	55 <input type="checkbox"/> Abnormal craving for sweets or snacks
45 <input type="checkbox"/> Irritable before meals	52 <input type="checkbox"/> Awaken after few hours sleep - hard to get back to sleep	
46 <input type="checkbox"/> Get "shaky" if hungry		
47 <input type="checkbox"/> Fatigue, eating relieves		
48 <input type="checkbox"/> "Lightheaded" if meals delayed		
<b>GROUP FOUR</b>		
56 <input type="checkbox"/> Hands and feet go to sleep easily, numbness	63 <input type="checkbox"/> Get "drowsy" often	68 <input type="checkbox"/> Bruise easily, "black and blue" spots
57 <input type="checkbox"/> Sigh frequently, "air hunger"	64 <input type="checkbox"/> Swollen ankles worse at night	69 <input type="checkbox"/> Tendency to anemia
58 <input type="checkbox"/> Aware of "breathing heavily"	65 <input type="checkbox"/> Muscle cramps, worse during exercise; get "charley horses"	70 <input type="checkbox"/> "Nose bleeds" frequent
59 <input type="checkbox"/> High altitude discomfort	66 <input type="checkbox"/> Shortness of breath on exertion	71 <input type="checkbox"/> Noises in head, or "ringing in ears"
60 <input type="checkbox"/> Opens windows in closed room	67 <input type="checkbox"/> Dull pain in chest or radiating into left arm, worse on exertion	72 <input type="checkbox"/> Tension under the breastbone, or feeling of "tightness", worse on exertion
61 <input type="checkbox"/> Susceptible to colds and fevers		
62 <input type="checkbox"/> Afternoon "yawner"		

**GROUP FIVE**

- |   |  |   |
|---|--|---|
| 73 <input type="checkbox"/> Dizziness                                   | 83 <input type="checkbox"/> Feeling queasy; headache over eyes           | 91 <input type="checkbox"/> Sneezing attacks                    |
| 74 <input type="checkbox"/> Dry skin                                    | 84 <input type="checkbox"/> Greasy foods upset                           | 92 <input type="checkbox"/> Dreaming, nightmare type bad dreams |
| 75 <input type="checkbox"/> Burning feet                                | 85 <input type="checkbox"/> Stools light-colored                         | 93 <input type="checkbox"/> Bad breath (halitosis)              |
| 76 <input type="checkbox"/> Blurred vision                              | 86 <input type="checkbox"/> Skin peels on foot soles                     | 94 <input type="checkbox"/> Milk products cause distress        |
| 77 <input type="checkbox"/> Itching skin and feet                       | 87 <input type="checkbox"/> Pain between shoulder blades                 | 95 <input type="checkbox"/> Sensitive to hot weather            |
| 78 <input type="checkbox"/> Excessive falling hair                      | 88 <input type="checkbox"/> Use laxatives                                | 96 <input type="checkbox"/> Burning or itching anus             |
| 79 <input type="checkbox"/> frequent skin rashes                        | 89 <input type="checkbox"/> Stools alternate from soft to watery         | 97 <input type="checkbox"/> Crave sweets                        |
| 80 <input type="checkbox"/> Bitter, metallic taste in mouth in mornings | 90 <input type="checkbox"/> History of gallbladder attacks or gallstones |   |
| 81 <input type="checkbox"/> Bowel movements painful or difficult        |  |   |
| 82 <input type="checkbox"/> Worrier, feels insecure                     |  |   |

**GROUP SIX**

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| 98 <input type="checkbox"/> Loss of taste for meat                       | 101 <input type="checkbox"/> Coated tongue   | 104 <input type="checkbox"/> Mucous colitis or "irritable bowel" |
| 99 <input type="checkbox"/> Lower bowel gas several hours after eating   | 102 <input type="checkbox"/> Pass large amounts of foul-smelling gas                       | 105 <input type="checkbox"/> Gas shortly after eating            |
| 100 <input type="checkbox"/> Burning stomach sensations, eating relieves | 103 <input type="checkbox"/> Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hours | 106 <input type="checkbox"/> Stomach "bloating" after eating     |

**GROUP SEVEN**

- |   |   |   |  |
|---|---|---|--|
| <b>(A)</b>  |   | <b>(E)</b>  |  |
| 107 <input type="checkbox"/> Insomnia                                   |   | 150 <input type="checkbox"/> Dizziness                            |  |
| 108 <input type="checkbox"/> Nervousness                                |   | 151 <input type="checkbox"/> Headaches                            |  |
| 109 <input type="checkbox"/> Can't gain weight                          |   | 152 <input type="checkbox"/> Hot flashes                          |  |
| 110 <input type="checkbox"/> Intolerance to heat                        | 137 <input type="checkbox"/> Failing memory                           | 153 <input type="checkbox"/> Increased blood pressure             |  |
| 111 <input type="checkbox"/> Highly emotional                           | 138 <input type="checkbox"/> Low blood pressure                       | 154 <input type="checkbox"/> Hair growth on face or body (female) |  |
| 112 <input type="checkbox"/> Flush easily                               | 139 <input type="checkbox"/> Increased sex drive                      | 155 <input type="checkbox"/> Sugar in urine (not diabetes)        |  |
| 113 <input type="checkbox"/> Night sweats                               | 140 <input type="checkbox"/> Headaches, "splitting or rendering" type | 156 <input type="checkbox"/> Masculine tendencies (female)        |  |
| 114 <input type="checkbox"/> Thin, moist skin                           | 141 <input type="checkbox"/> Decreased sugar tolerance                |   |  |
| 115 <input type="checkbox"/> Inward trembling                           |   | <b>(F)</b>  |  |
| 116 <input type="checkbox"/> Heart palpitates                           | 142 <input type="checkbox"/> Abnormal thirst                          | 157 <input type="checkbox"/> Weakness, dizziness                  |  |
| 117 <input type="checkbox"/> Increased appetite without weight gain     | 143 <input type="checkbox"/> Bloating of abdomen                      | 158 <input type="checkbox"/> Chronic fatigue                      |  |
| 118 <input type="checkbox"/> Pulse fast at rest                         | 144 <input type="checkbox"/> Weight gain around hips or waist         | 159 <input type="checkbox"/> Low blood pressure                   |  |
| 119 <input type="checkbox"/> Eyelids and face twitch                    | 145 <input type="checkbox"/> Sex drive reduced or lacking             | 160 <input type="checkbox"/> Nails, weak, ridged                  |  |
| 120 <input type="checkbox"/> Irritable and restless                     | 146 <input type="checkbox"/> Tendency to ulcers, colitis              | 161 <input type="checkbox"/> Tendency to hives                    |  |
| 121 <input type="checkbox"/> Can't work under pressure                  | 147 <input type="checkbox"/> Increased sugar tolerance                | 162 <input type="checkbox"/> Arthritic tendencies                 |  |
|   | 148 <input type="checkbox"/> Women: menstrual disorders               | 163 <input type="checkbox"/> Perspiration increase                |  |
|   | 149 <input type="checkbox"/> Young girls: lack of menstrual function  | 164 <input type="checkbox"/> Bowel disorders                      |  |
|   |   | 165 <input type="checkbox"/> Poor circulation                     |  |
| <b>(B)</b>  |   | 166 <input type="checkbox"/> Swollen ankles                       |  |
| 122 <input type="checkbox"/> Increase in weight                         |   | 167 <input type="checkbox"/> Crave salt                           |  |
| 123 <input type="checkbox"/> Decrease in appetite                       |   | 168 <input type="checkbox"/> Brown spots or bronzing of skin      |  |
| 124 <input type="checkbox"/> Fatigue easily                             |   | 169 <input type="checkbox"/> Allergies - tendency to asthma       |  |
| 125 <input type="checkbox"/> Ringing in ears                            |   | 170 <input type="checkbox"/> Weakness after colds, influenza      |  |
| 126 <input type="checkbox"/> Sleepy during day                          |   | 171 <input type="checkbox"/> Exhaustion - muscular and nervous    |  |
| 127 <input type="checkbox"/> Sensitive to cold                          |   | 172 <input type="checkbox"/> Respiratory disorders                |  |
| 128 <input type="checkbox"/> Dry or scaly skin                          |   |   |  |
| 129 <input type="checkbox"/> Constipation                               |   |   |  |
| 130 <input type="checkbox"/> Mental sluggishness                        |   |   |  |
| 131 <input type="checkbox"/> Hair coarse, falls out                     |   |   |  |
| 132 <input type="checkbox"/> Headaches upon arising wear off during day |   |   |  |
| 133 <input type="checkbox"/> Slow pulse, below 65                       |   |   |  |
| 134 <input type="checkbox"/> Frequency of urination                     |   |   |  |
| 135 <input type="checkbox"/> Impaired hearing                           |   |   |  |
| 136 <input type="checkbox"/> Reduced initiative                         |   |   |  |

GROUP EIGHT	FEMALE ONLY	MALE ONLY
173 <input type="checkbox"/> Apprehension	200 <input type="checkbox"/> Very easily fatigued	213 <input type="checkbox"/> Prostate trouble
174 <input type="checkbox"/> Irritability	201 <input type="checkbox"/> Premenstrual tension	214 <input type="checkbox"/> Urination difficult or dribbling
175 <input type="checkbox"/> Morbid fears	202 <input type="checkbox"/> Painful menses	215 <input type="checkbox"/> Night urination frequent
176 <input type="checkbox"/> Never seems to get well	203 <input type="checkbox"/> Depressed feelings before menstruation	216 <input type="checkbox"/> Depression
177 <input type="checkbox"/> Forgetfulness	204 <input type="checkbox"/> Menstruation excessive and prolonged	217 <input type="checkbox"/> Pain on inside of legs or heels
178 <input type="checkbox"/> Indigestion	205 <input type="checkbox"/> Painful breasts	218 <input type="checkbox"/> Feeling of incomplete bowel evacuation
179 <input type="checkbox"/> Poor appetite	206 <input type="checkbox"/> Menstruate too frequently	219 <input type="checkbox"/> Lack of energy
180 <input type="checkbox"/> Craving for sweets	207 <input type="checkbox"/> Vaginal discharge	220 <input type="checkbox"/> Migrating aches and pains
181 <input type="checkbox"/> Muscular soreness	208 <input type="checkbox"/> Hysterectomy/ovaries removed	221 <input type="checkbox"/> Tire too easily
182 <input type="checkbox"/> Depression; feelings of dread	209 <input type="checkbox"/> Menopausal hot flashes	222 <input type="checkbox"/> Avoids activity
183 <input type="checkbox"/> Noise sensitivity	210 <input type="checkbox"/> Menses scanty or missed	223 <input type="checkbox"/> Leg nervousness at night
184 <input type="checkbox"/> Acoustic hallucinations	211 <input type="checkbox"/> Acne, worse at menses	224 <input type="checkbox"/> Diminished sex drive
185 <input type="checkbox"/> Tendency to cry without reason	212 <input type="checkbox"/> Depression of long standing	
186 <input type="checkbox"/> Hair is coarse and/or thinning		
187 <input type="checkbox"/> Weakness		
188 <input type="checkbox"/> Fatigue		
189 <input type="checkbox"/> Skin sensitive to touch		
190 <input type="checkbox"/> Tendency toward hives		
191 <input type="checkbox"/> Nervousness		
192 <input type="checkbox"/> Headache		
193 <input type="checkbox"/> Insomnia		
194 <input type="checkbox"/> Anxiety		
195 <input type="checkbox"/> Anorexia		
196 <input type="checkbox"/> Inability to concentrate; confusion		
197 <input type="checkbox"/> Frequent stuffy nose; sinus infections		
198 <input type="checkbox"/> Allergy to some foods		
199 <input type="checkbox"/> Loose joints		