

Name: _____ Age: _____ Phone: _____

Address: _____

PAST MEDICAL HISTORY

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Stroke | <input type="checkbox"/> Venereal diseases/STD's |
| <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Heart Disease/angina | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Chlamydia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis/jaundice | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Gonorrhoea |
| <input type="checkbox"/> Cancer, type _____ | <input type="checkbox"/> High cholesterol-cholesterol # _____ | <input type="checkbox"/> Vaginal yeast infections | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | | |

PAST SURGICAL HISTORY

- | | | | |
|--|--|---|-------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Thyroid | Other _____ |
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Tonsils and/or adenoids | _____ |
| <input type="checkbox"/> Back | <input type="checkbox"/> Hernia | <input type="checkbox"/> Uterus | |
| <input type="checkbox"/> Breast-
Benign Cancerous | <input type="checkbox"/> Prostate-
Benign Cancerous | <input type="checkbox"/> Did they remove both ovaries? Yes no | |

ALLERGIES

Drugs: <input type="checkbox"/> None, otherwise list:	Foods: <input type="checkbox"/> None, otherwise list:	Inhalants: <input type="checkbox"/> None, otherwise list:	Other:

CURRENT MEDICINES

Name: <input type="checkbox"/> None, otherwise list:	Dose:	Frequency:	Name:	Dose:	Frequency:

SOCIAL HISTORY / HABITS

- Smoke Never Quit (yr.) _____ Yes (smoke currently) _____ #pack/day _____ # of years
- Alcohol Never Quit (yr.) _____ Rare Moderate Daily
- Caffeine/Coffee Never Yes _____ Cups/day, total caffeine intake (average) _____
- Occupation: None Retired Other (please state): _____

DIET (include drinks – coffee, soft drinks, etc.)

Typical Breakfast:	Foods you like to eat a lot of (milk, wheat, sweets, etc.):
Typical Lunch:	
Typical Dinner:	Do you feel excessively sleepy after meals? Yes No
	Do you crave sweets? Yes No
Snacks through the day:	Do you consume cow's milk products regularly (such as milk, ice cream, cheese, yogurt, butter, etc.)? Yes No

Please answer the following questions to the best of your ability. This questionnaire refers to trends more than isolated events in your past history.

General:

Gained or lost weight recently?Yes No
Tendency to be too hot or cold?Yes No
Trouble falling asleep?Yes No
Exercise regularly (3 or more times / week?:Yes No
Other than to urinate, do you wake up during the night? ...Yes No
Time arising: _____

Skin:

Hives, eczema or chronic rashes?Yes No
Past or frequent athletes foot/jock itch?Yes No
Chronic fingernail or toenail infections?Yes No
Nails split, break or grow abnormally?Yes No

Head, ears, eyes, nose, throat and neck:

Excessive sneezing or runny nose?Yes No
Frequent nose bleeds?Yes No
Sinus problems?Yes No
Thyroid problems or enlarged glands?Yes No

Respiratory:

Chronic or frequent coughs?Yes No
Phlegm or mucous productions each day?Yes No
What color? _____
Asthma or wheezing?Yes No
Short of breath easily?Yes No
If yes, do you gasp?Yes No

Cardiovascular:

Frequent thumping/racing/irregular heartbeats?Yes No
Pain or tightness in your chest?Yes No
Short of breath lying down or walking?Yes No
Frequently swollen feet or ankles?Yes No
Heart troubles or angina?Yes No
Heart murmur?Yes No
Varicose veins?Yes No

Gastrointestinal:

Bloating after eating?Yes No
Stomach ulcers?Yes No
Gallbladder disease?Yes No
Recent change in bowel habits?Yes No
Frequent diarrhea or constipation?Yes No
Heartburn, indigestion or gas?Yes No
Have you ever had parasites?Yes No

Genitourinary:

Burning or pain with urination?Yes No
Kidney trouble or stones?Yes No

Men Only:

Is your urine stream weak or slow?Yes No
Prostate problem?Yes No
Swelling/lumps on your testicles?Yes No
Problems with erections?Yes No

Gynecological (women only):

Trouble with your menstrual periods?Yes No
Heavy clotting or pain with mensesYes No

Approximate days between periods _____
List PMS symptoms _____
of pregnancies _____ # of children _____
Breast tendernessYes No
Frequent vaginal infections?Yes No
Frequent yeast infections?Yes No
Date of last pap? _____
If menopausal, what year? _____

Hematologic:

Anemic or prone to anemia?Yes No
Bruise or bleed easily?Yes No

Musculoskeletal:

Chronic back pain or neck problems?Yes No
Stiff or painful muscles or joints?Yes No
Swollen joints?Yes No
Legs cramp at night?Yes No
Leg cramps when you walk?Yes No

Neuropsychiatry / Endocrine:

Headaches?Yes No
Numbness or tingling anywhere?Yes No
Feel lonely or depressed?Yes No
Sexual difficulties?Yes No
Past physical, emotional or sexual abuse?Yes No
Present physical, emotional or sexual abuse?Yes No
Have you ever seen a psychiatrist or psychologists?Yes No

Environmental / Occupational History:

What do you do for a living? _____
Are you exposed to gases, fuels, chemicals or solvents at work, home or with your hobby?Yes No
If so, what substances _____
Smoker in the house?Yes No
Do you have a wood stove?Yes No
Is your house painted with lead-based paint?Yes No
Do you have pets?Yes No
Inside _____ or outside _____ the house?
Do they sleep in your bedroom?Yes No
Dusty house?Yes No
Mold in the bedroom, around the windows or near the washer and dryer?Yes No
Are you indoors most of the day away from sunlight?Yes No
Are there any other environmental factors that you can think of that may be affecting your health?Yes No

Goals for Your Health:

