

NAME: _____

DATE: _____

Present Complaint: _____

When did it begin ? (date) _____

What percent of time does it bother you ? (circle one) <10% 25% 50% 75% 100%

List your 3 major health concerns in order of importance:

- 1) _____
- 2) _____
- 3) _____

What treatments (if any) have you received for your present condition(s)? _____

Surgeries or Hospitalizations: _____

Medications and conditions for which you are currently taking:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Supplements and conditions for which you are currently taking:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Do you exercise? None Light Moderate Strenuous

Sleep (# of hours and quality): _____

Allergies:

Medications: _____

Food: _____

Environmental: _____

Family Health History - Which relative?

Diabetes _____	Heart Disease _____	Stroke _____
Cancer _____	Lung Disease _____	Thyroid _____
Psychiatric _____	High blood pressure _____	

Do you use any of the following: Alcohol _____ Tobacco _____ Caffeine _____

Medical Problems: check appropriate box

Head	PAST	PRESENT
Epilepsy		
Allergies		
Headaches		
Migraines		
Dizziness		
Fainting		
Sinus problems		
Stroke		

Eyes, Ears, Nose, Throat	PAST	PRESENT
Sore throat		
Sore tongue		
Sore gums		
Swollen glands		
Eye pain		
Watery, itchy red eyes		
Dry eyes		
Dark circles below eyes		
Double vision		
Blurred vision		
Poor vision		
Glaucoma		
Yellowing eyes		

Heart	PAST	PRESENT
Anemia		
High blood pressure		
Kidney disease		
Cholesterol problems		
Varicose veins		
Easy bleeding/bruising		
Coronary Disease		
Heart attack		
Heart murmur		

Other	PAST	PRESENT
Alcoholism		
Cancer		
Diabetes		
Thyroid disease		
Overweight		
Fatigue		
Insomnia		
Weight loss		
Weight gain		

Musculoskeletal	PAST	PRESENT
Muscle pain		
Joint pain		
Arthritis		
Back pain		

Skin	PAST	PRESENT
Rashes		
Discoloration		
Itching		

Stomach/Digestive	PAST	PRESENT
Liver disease		
Hemorrhoids		
Hypoglycemia (low blood sugar)		
Stomach pain		
Ulcers		
Gas/Bloating		
Indigestion		
Nausea/vomiting		
Vomiting blood		
Difficulty swallowing		
Burning in throat		
Heartburn		
Black stools		
Diarrhea		
Constipation		
Rectal bleeding		
Hemorrhoids		

Lungs	PAST	PRESENT
Asthma		
Emphysema		
Bronchitis		
Pneumonia		
Wheezing		
Cough		

Mental/Emotional	PAST	PRESENT
Anxiety or Depression		
Counseling		
Poor memory		
Sleeping difficulty		
Awaken rested		

Medical Problems: check appropriate box

FEMALE ONLY	PAST	PRESENT
Last period		
Age of onset at period		
Irregular periods		
Excessive pain/bleeding with periods		
Bleeding between periods		
# of pregnancies		
Birth Control Pills		
Hormone Replacement Therapy		
Routine annual Breast Exam		
Routine annual Pelvic exam		
Routine mammogram		
Breast Cysts		
PCOS (Polycystic Ovarian Syndrome)		
Endometriosis		
Vaginal itching/dryness		
Sexual dysfunction		
Ovarian cysts/Uterine fibroids		
Age at menopause		
Bleeding after menopause		

MEN ONLY	PAST	PRESENT
Prostate disease		
Forked stream		
Impotence		
Sexual dysfunction		
Enlarged breasts		
Low Sex Drive		
Discharge		

CHILDREN ONLY	PAST	PRESENT
Ear aches/infections		
Allergies		
Red, itchy eyes		
Runny nose		
Sneezing		
Enlarged tonsils		
Tonsiitis/Tonsilectomy		
Discipline problems		
Learning problems		
Fatigue		
Difficulty gaining weight		
Problems in school		
Bedwetting		
Diarrhea		
Constipation		
Dry, itchy skin		
Temperament issues		
Other		