Past Health History Assessment

Past Illnesses				
Some conditions may be experienced more than once; therefore, please indicate any multiple illnesses via the “date” columns.				
Illness	**Date**	**Date**	**Date**	**Comments**
Chicken Pox				
German Measles				
Measles				
Mononucleosis				
Mumps				
Whooping Cough				
Anemia				
Arthritis				
Asthma				
Bronchitis				
Cancer				
Chronic Fatigue				
Crohn’s Disease or Ulcerative Colitis				
Diabetes				
Emphysema				
Epilepsy, Convulsions				
Gallstones				
Gout				
Heart Attack/Angina				
Heart Failure				
Hepatitis				
Hugh Blood Pressure				
Irritable Bowel				
Kidney Stones				

Past Illnesses				
Some conditions may be experienced more than once; therefore, please indicate any multiple illnesses via the “date” columns.				
Illness	**Date**	**Date**	**Date**	**Comments**
Mononucleosis				
Pneumonia				
Rheumatic Fever				
Shingles				
Sinusitis				
Sleep Apnea				
Stroke				
Thyroid Disease				
Other (describe)				

Hospitalizations		
Where Hospitalized	**When**	**For What Reason**

Birth History				
Question	**Yes**	**No**	**Don’t Know**	**Comment**
Were you a full-term baby?				
A Preemie?				
Forcep delivery?				
Cesarean section?				
Epidural used?				
Breast fed?				
When your mother was pregnant with you, did she:				

Birth History				
Smoke tobacco?				
Drink alcohol?				
Take estrogen?				
Take pre-natal vitamins?				

Childhood Health History				
Question	**Yes**	**No**	**Don't Know**	**Comment**
Did you live in an area with soft water?				
Hard water?				
As a child, did you consume a lot of the following:				
Question	**Yes**	**No**	**Don't Know**	**Comment**
Sugar?				
Candy?				
Sweet foods?				
Soda?				
Diet soda?				
White bread?				
Cookies?				
Ice cream?				
Meat, vegetable & potato/rice/pasta diet?				
Vegetarian & grain based diet with little meat?				
Vegetarian diet with milk & eggs?				
Vegetarian diet without milk & eggs?				

Childhood Food Symptoms		
As a child, were there any foods that you had to avoid because they gave you symptoms? If so, please name the food and symptom (e.g. wheat – gas and bloating)		
Food	**Symptom**	**Other comments**

Age of Onset of Illnesses

Please indicate which, if any, of the following problems/conditions developed when you were a child (ages birth to age12) by indicating the approximate age of onset.

_____ Abusive or alcoholic parent(s)
_____ ADD
_____ Behavior problems
_____ Bronchitis
_____ Chicken pox
_____ Colic
_____ Congenital abnormalities
_____ Difficulty learning
_____ Ear infections
_____ Fever blisters
_____ Frequent colds or flu
_____ Frequent headaches
_____ High # of absences from school
_____ Hyperactivity
_____ Jaundice
_____ Measles
_____ Mumps
_____ Parent(s) smoked
_____ Pneumonia
_____ Premature at birth
_____ Seasonal allergies
_____ Significant dental work
_____ Skin disorders (eczema)
_____ Strep infections
_____ Tonsillitis
_____ Upset stomach, indigestion
_____ Whooping cough

Did you have any major childhood illness(es) that required hospitalization? ❑ Yes ❑ No
If yes, please explain (include age of any): _____
_____
_____

Immunization History

Please indicate if you have been vaccinated against any of the following diseases:

- ❑ Smallpox
- ❑ Tetanus
- ❑ Diphtheria
- ❑ Pertussis
- ❑ Polio (oral)
- ❑ Polio (injection)
- ❑ Mumps
- ❑ Measles
- ❑ Rubella (German measles)
- ❑ Typhoid
- ❑ Cholera
- ❑ Flu
- ❑ Chickenpox
- ❑ HPV
- ❑ Shingles
- ❑ Pneumonia
- ❑ Meningitis
- ❑ Hepatitis A
- ❑ Hepatitis B

Female Medical History

Obstetrics History: Check box if yes and provide number of

- ❑ Pregnancies _____
- ❑ Caesarean _____
- ❑ Vaginal deliveries _____
- ❑ Miscarriage _____
- ❑ Abortion _____
- ❑ Living children _____
- ❑ Post-partum depression _____
- ❑ Toxemia _____
- ❑ Gestational diabetes _____
- ❑ Baby over 8 pounds _____
- ❑ Breast feeding -- for how long? _____

Gynecological History

Age at 1st period _____ Menses frequency _____ Length _____

Pain ❑ Yes ❑ No Clotting ❑ Yes ❑ No

Has your period skipped? _____ For how long? _____

Last menstrual period _____

Do you currently use contraception? ❑ Yes ❑ No

If yes, what type do you use? ❑ Condom ❑ Diaphragm ❑ IUD ❑ Partner vasectomy

❑ Other _____

Gynecological History - continued

Have you ever used hormonal contraception? ❑ Yes ❑ No If yes, when _____

Use of hormonal contraception ❑ Birth control pills ❑ Patch ❑ Nuva Ring

How long? _____

Are you using the pill now? ❑ Yes ❑ No

Did taking the pill agree with you? ❑ Yes ❑ No

In the 2nd half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? ❑ Yes ❑ No

Last mammogram _____

Breast biopsy/date _____

Thermograms:

Baseline _____

2nd thermogram _____

Grade _____

Last PAP test _____ Results ❑ Normal ❑ Abnormal

Date of last bone density test _____

Results ❑ High ❑ Low ❑ Within normal range

Are you in menopause? ❑ Yes ❑ No

Age at Menopause _____

Do you take ❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone ❑ Provera ❑ Other _____

How long have you been on hormone replacement? _____