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HEALTH HISTORY FORM

Name _____ Date _____

Address _____ Home Phone _____

_____ Alternate Phone _____

_____ Email _____

Date of Birth _____ M__ F__ Marital Status _____ No. of Children _____

Occupation _____ Height _____ Weight _____

Employer _____

Referred By _____ Social Security No. _____

CHIEF COMPLAINT (Please explain the nature of your health concern and what you hope to receive from treatment)

FAMILY HISTORY (Check any disorders you or your family have experienced)

	You	Father	Mother	Sibling	Children
Allergies	☐	☐	☐	☐	☐
Blood disorder/Anemia	☐	☐	☐	☐	☐
Cancer/Tumors	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Heart Disorder	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐

PERSONAL HISTORY

▶ *Hospitalizations/Medications*

Date	Reason/Outcome

Please list any medications or supplements that you are currently taking

For what conditions _____

Please list any drug sensitivities you have _____

Date of last physical examination _____

Name and address of primary care practitioner _____

_____

▶ ***Diet***

Breakfast _____

Lunch _____

Dinner _____

Cravings (sweet, salty, bitter, greasy, spicy) _____

How many cups a day do you drink of the following?

Water _____ Soda _____ Coffee _____ Tea _____ Alcohol _____

Do you perspire during the day? _____ Do you perspire at night? _____

Are you always thirsty? _____

Do you prefer hot, iced, or room temperature drinks? (circle one)

List any known food allergies _____

▶ ***Exercise and energy***

What kind of exercise do you engage in? _____

How often? _____ How is your energy level? (100% is best what is yours percentage?) _____

Do you have or have you had? (check all that apply)

- ☐ Panic attacks
- ☐ Depression
- ☐ Anxiety/nerves
- ☐ Fear
- ☐ Difficulty concentrating
- ☐ Poor memory
- ☐ Difficulty falling asleep
- ☐ Restlessness
- ☐ Disturbed sleep
- ☐ Waking up at am/pm
- ☐ Recent divorce or major stress

Have you ever taken antidepressants? _____ What kind? _____

Have you ever taken sleeping pills? _____ What kind? _____

▶ ***Gastrointestinal***

Do you have or have you had? (check all that apply)

- ☐ Belching
- ☐ Nausea
- ☐ Ulcers
- ☐ Bloating
- ☐ Indigestion
- ☐ Acid reflux
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Abdominal pain

Bowel movements: How often? _____

- ☐ Constipation
- ☐ Diarrhea

▶ ***Urinary*** (check all that apply)

- ☐ Frequent urination, how often? _____
- ☐ Incontinence
- ☐ Burning sensation
- ☐ Bladder Infection

▶ ***Gynecological***

☐ Are you still menstruating? How often are your cycles? _____

Do you have or have you had? (check all that apply)

- ☐ Irregular menses
- ☐ Heavy flow, what day/s of cycle _____
- ☐ Heavy flow, what day/s of cycle _____
- ☐ Blood clots
- ☐ PMS, what symptoms _____
- ☐ Painful periods, what day of cycle _____
- ☐ Uterine fibroids or cysts
- ☐ Endometriosis
- ☐ Cystic Breasts
- ☐ Perimenopausal, what symptoms _____
- ☐ Menopausal

Date of last menstrual period _____

▶ ***Muscular-skeletal***

Do you have or have you had? (check all that apply)

- ☐ Muscle pain
- ☐ Back pain
- ☐ Pain elsewhere in the body, & if so, where? _____
- ☐ Arthritis
- ☐ Joint pain

▶ ***Respiratory, ENT & Head***

Do you smoke? _____ How many times a day? _____ For how many years? _____

Do you have or have you had? (check all that apply)

- ☐ Frequent colds
- ☐ Bleeding gums
- ☐ Clogged/popping ears
- ☐ Asthma
- ☐ Dry mouth
- ☐ Frequent headaches
- ☐ Dizziness
- ☐ Ringing in ears
- ☐ Migraine

▶ ***Cardiovascular***

Do you have or have you had? (check all that apply)

- ☐ Palpitations
- ☐ Cold hands/feet
- ☐ Spider veins
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Swollen hands/feet
- ☐ Heart murmur
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Varicose veins

▶ ***Skin & Hair***

Do you have or have you had? (check all that apply)

- ☐ Dry skin
- ☐ Acne
- ☐ Hives
- ☐ Oily skin
- ☐ Skin rashes
- ☐ Hair loss
- ☐ Itching
- ☐ Eczema

What treatment have you received for these conditions? _____

_____

What is your skin care regimen? _____

_____

Are there any other health conditions I should be informed of?

_____

_____

_____

Thank you!

FOR OFFICE USE ONLY

Dx:

T:

P:

PTS:

RX

Notes: