HEALTH HISTORY

Today's Date_____
Patient Name_____Birth Date_____/_____/_____
Additional Physicians_____Phone_____

Goals for Treatment: *Please list (in order of importance) the present health concerns, symptoms, or problems you are experiencing that you would like to discuss.*

Current Health History: *Please list any current health conditions that you have such as cancer, diabetes, infections, eczema, mental illnesses, etc.*

Medications: *Please list all medicines you are currently taking (including supplements and non-prescription drugs). Please include frequency and amount if possible. Please bring in all containers with you if possible.*

Product Name Amount Frequency

Blood work: *What was the last date of blood work?*_____
*What tests were performed?*_____
*Were there abnormal results?*_____

Allergies: *Please list all allergies that you have to any drugs, herbs, foods, animals, or other. Please also indicate specific information on your reactions.*

Habits: *Please list all habits including coffee, soda, alcohol, smoking, etc (Please include amounts and frequency).*

_____
_____
_____
_____

Vaccines: *Check all vaccines that you've completed and the dates in which you got them.*

___Tetanus_____
___Pertussis_____
___Meningococcal_____
___Pneumococcal_____
___Hepatitis B_____
___ Varicella_____
___MMR(Measles, Mumps, Rubella)_____
___Diphtheria_____
___Human Papillomavirus_____
___Yearly Influenza_____
___Hepatitis A_____
___Poliovirus_____

Past Conditions*:*
What childhood illnesses have you had:

___Measles ___Mumps ___Chicken Pox ___Polio
___Whooping Cough ___Diphtheria ___Rheumatic Fever ___Smallpox
___Scarlet Fever ___Typhoid Fever ___Tuberculosis
___Mononucleosis: How Long: _____ Any Complications:_____

*Previous Surgeries and hospitalizations (Include dates):*_____
_____
_____
_____
_____

Which of the following have you had and please indicate dates effected:

_____Pneumonia _____Diabetes _____Gonorrhea
_____Tonsillitis _____Asthma _____Syphilis
_____Ear Infection _____Eczema _____Venereal Disease
_____Chronic Infections _____Heart Disease _____Epilepsy
_____Canker Sores _____High Blood Pressure _____Herpes
_____Seasonal Allergies _____Hepatitis _____Mononucleosis
_____Thyroid Problems _____Weight Problems _____Anemia
_____Seizures _____Ulcers _____Cataracts
_____Depression _____Arthritis
Other_____
_____
_____
_____

Family History

Please indicate if you have any family members (biological siblings, parents, grandparents) who have any of the following:

___High Blood Pressure *Relation to you:*_____
___Heart Disease *Relation to you:*_____
___Diabetes *Relation to you:*_____
___Stroke *Relation to you:*_____
___Osteoporosis *Relation to you:*_____
___Bleeding abnormalities *Relation to you:*_____
___Anemia *Relation to you:*_____
___Arthritis *Relation to you:*_____
___Asthma *Relation to you:*_____
___Cataracts *Relation to you:*_____
___Thyroid Problems *Relation to you:*_____
___Sickle Cell Disease *Relation to you:*_____
___Seizures *Relation to you:*_____
___Genetic Condition *Relation to you, and what condition:*_____
___Substance Abuse (alcohol/street drugs/prescription drugs)
*Relation to you, and what abuse:*_____
___Female family members with hysterectomies, fibroids, endometriosis
*Relation to you, and which one:*_____
___Migraines *Relation to you:*_____
___Mental Illness *Relation to you, and what illness:*_____
___Autoimmune conditions *Relation to you and what condition:*_____
___Cancer
___Breast ___Lung
___Ovarian ___Blood (Leukemia/lymphoma)
___Uterine ___Colon
___Cervical ___Skin
*Relation to you:*_____
___Other:_____

_____
_____
_____

Men Only

Circle yes or no, or leave blank

Urination Changes or Difficulties	YES	NO	
Night Urination	YES	NO	
Sexual Dysfunction	YES	NO	
Sores on penis	YES	NO	
Prostate Problems	YES	NO	
Previous prostate examinations	YES	NO	When?_____
Abnormal Discharge	YES	NO	
Currently sexually active	YES	NO	How often?_____

Women Only

Circle yes or no, or leave blank

Problems with menstrual cycle YES NO

If yes please explain _____

_____

Vaginal itching or discharge YES NO

Number of pregnancies_____ Number of live births_____

Hot flashes or night sweats YES NO

If yes, how often_____

Do you get yearly PAP smears YES NO

Are your cycles regular YES NO

Currently sexually active YES NO How often?_____

Do you use birth control YES NO

Do you have any premenstrual symptoms? (**Water retention, breast tenderness, irritability, depression, headaches, mood swings, food cravings, acne)**Other:_____

_____

Breast lumps YES NO

Do you get yearly mammograms YES NO

Religion and Culture

Are there any religion or culture preferences that you have that might alter or change the type of treatment we may perform?

_____

_____

_____

_____

_____

To the best of my knowledge, the above information is correct. I understand that giving inaccurate information may harm me or my child's medical status. I authorize the health care staff to perform necessary health care services.

Patient's Signature_____ Date_____