Health History

Please fill out the following information, placing any comments in the columns or on the back of these sheets.

Name ____ Date _____________
Age ____________ Date of Birth _____________ Sex: M F Married? _______________
Mailing Address ____
Home Telephone ____________________________ Other Telephone ____________________
Email Address ____
Occupation/Profession ____
Employer ____
Spouse's Name ___________________________ Spouse's Work Number _________________

Doctor's Name ________________________________ Office Telephone __________________
Street Address ____

Have you been diagnosed with any health condition(s)?
____
List any accidents or falls and dates:
____
List any broken bones (fractures) or dislocations:
____

Do you smoke? ________ How many packs per day? _______________
Do you drink alcohol? __________ How many packs per day? _____________
Do you drink coffee? __________ How many cups per day? ______________
Do you drink soda? _________ What kinds? ______________ How often? _________________
Do you drink store-bought juice? _________ store-bought milk? ___________
Do you have any food cravings? ____
Are you following any particular diet? __________ If so, please describe: __________________
____
Are you using any medications? _________ Please list type, amount, and frequency:
____
____
Are you using any nutritional supplements? ____________ Please list type, amount, and frequency:
____
____

Family History

	Diabetes?	Heart Disease?	Kidney Disease?	Cancer?	Other?
Mother					
Father					
Siblings					
Maternal grandparents					
Paternal grandparents					

Have you ever had any operations? ____
Have you ever been hospitalized? ____

Have you ever had any of the following diseases?

___Appendicitis
___Pneumonia
___Rheumatic fever
___Polio
___Tuberculosis
___Whooping Cough
___Chicken Pox
___Mumps
___Cancer
___Heart disease
___Goiter
___Influenza
___Arthritis
___Epilepsy
___Mental disorder
___Lumbago
___Eczema
___AIDS
___Measles
___Diabetes
___Venereal Infection
___Alcoholism
___Pleurisy
___Anemia

Please enter "2" for Previously, "3" for Presently, for each of the following signs and symptoms. Leave blank if it does not apply.

General Symptoms

___Headache
___Fever
___Chills
___Night sweats
___Fainting
___Dizziness
___Convulsions
___Loss of sleep
___Fatigue
___Nervousness
___Loss of weight
___Allergy
___Wheezing
___Neuralgia
___Numbness or pain in arms, legs, hands

Muscles & Joints

___Weakness
___Twitching
___Stiff neck
___Backache
___Swollen joints
___Tremors
___Foot trouble
___Painful tail bone
___Pain between shoulders
___Hernia
___Spinal curvature

Respiratory

___Chronic cough
___Spitting blood
___Spitting phlegm
___Chest Pain
___Difficulty breathing

Gastro-Intestinal

___Poor appetite
___Poor digestion
___Excessive hunger
___Belching or gas
___Nausea
___Vomiting
___Vomiting blood
___Pain over stomach
___Constipation
___Diarrhea
___Colon trouble
___Hemorrhoids
___Liver trouble
___Jaundice
___Gall bladder trouble

Cardio-Vascular

___Rapid heart
___Slow heart
___High blood pressure
___Low blood pressure
*normal is 120/80
___Pain over heart
___Previous heart trouble
___Swelling ankles
___Poor circulation
___Varicose veins
___Strokes

Genito-Urinary

___Frequent urination
___Painful urination
___Blood in urine
___Kidney infection
___Bed wetting
___Inability to control urine
___Prostrate trouble

Eye/Ear/Nose/Throat

___Poor vision
___Crossed eyes
___Pain in eyes
___Deafness
___Earache
___Ear noises
___Ear discharges
___Nasal obstruction
___Nose bleeds
___Sore throats
___Hoarseness
___Hay fever
___Asthma
___Frequent colds
___Enlarged thyroid
___Tonsillitis
___Sinus trouble
___Trouble swallowing

Skin or Allergies

___Skin eruptions
___Itching
___Bruising easily
___Dryness
___Boils
___Sensitive skin
___Hives or allergy
___Eczema

Women Only

___Painful periods
___Excessive flow
___Irregular cycles
___Hot flashes
___Cramps or backache
___Miscarriage
___Vaginal discharge
___Pregnant at this time
______ Date of last period
______ Date of period before that

Please try to list everything (food, drink, medication, supplements, etc.) that went into your mouth yesterday, including the times ingested:

Before 8 a.m.

Between 8 a.m. and noon:

Between noon and 4 p.m.:

Between 4 p.m. and 8 p.m.:

Between 8 p.m. and bedtime:

Was this a normal day of eating for you? _______ If not, please explain (maybe on back?):
What time do you usually go to bed at night? _________________
What time do you usually wake up in the morning? __________________
Do you sleep soundly? ____________ Do you have difficulty falling asleep? ______________ Do you have difficulty staying asleep all night? _______________
At what times of the day do you feel most energetic? ____
At what times of the day do you feel most tired? ____
Do you generally observe a "day of rest" each week? ____