Health History

Name: _____ Date: _____

Main concern or reason(s) for seeing the doctor:

_____

_____

_____

Personal

Major Illnesses (please give types and dates):

_____

_____

_____

Previous hospitalizations or surgeries:

_____

_____

Allergies:

_____

Family

Please list any major illnesses for the following BLOOD relatives:

Father:_____

Mother:_____

Siblings:_____

Other:_____

Social

Current Smoker? NO YES Past Smoker? NO YES Quit date:_____

If "yes" for either, how often and for how long?_____

Alcohol Consumption YES NO

If "yes", how often and how much? _____

Occupation: _____

Toxic Exposure: _____

Wellbeing

Name: _____ Date: _____

What are your health goals?

_____

_____

_____

What practices and/or activities do you use to sustain your health and wellbeing (religious, spiritual, what inspires you, etc.)? _____

_____

_____

Who do you turn to for support? _____

What causes you stress? _____

Who lives with you? _____

Health Issues

What do you think causes (caused) your health issues? _____

_____

How do(es) your health issue(s) effect you? _____

_____

How severe is the issue? How long do you think it will last? _____

_____

What type of treatment do you wish to receive? _____

_____

What else do you think will assist to resolve the issue? _____

_____

What is the most important result you hope to receive? _____

_____

What do you most fear most about your illness/injury? _____

_____

Review of Systems

Name: _____ Date: _____

Date of last medical exam: _____ Results: _____

Fever/chills/night sweats	NO	YES	Explain: _____
Skin rashes/itching	NO	YES	Explain: _____
Change in weight	NO	YES	Explain: _____
Shortness of breath	NO	YES	Explain: _____
Chest pain/pressure	NO	YES	Explain: _____
High blood pressure	NO	YES	Explain: _____
Coughing/phlegm	NO	YES	Explain: _____
Heart problem	NO	YES	Explain: _____
Nausea/vomiting	NO	YES	Explain: _____
Headache/dizziness	NO	YES	Explain: _____
Blood in stool/black stool	NO	YES	Explain: _____
Diarrhea/constipation	NO	YES	Explain: _____
Food intolerance/abdominal	NO	YES	Explain: _____
Urination problem	NO	YES	Explain: _____
Sexual/erectile dysfunction	NO	YES	Explain: _____
Fatigue/weakness	NO	YES	Explain: _____
Dental issues	NO	YES	Explain: _____
Change in vision/hearing	NO	YES	Explain: _____
Diabetes	NO	YES	Explain: _____
Pain/swelling/numbness	NO	YES	Explain: _____
Back pain	NO	YES	Explain: _____
Mood problem	NO	YES	Explain: _____
Difficulty sleeping	NO	YES	Explain: _____
Memory loss	NO	YES	Explain: _____

Female Only

Date of last Mammogram/PAP: _____ Results: _____

Pregnancy(s)	NO	YES	Date(s): _____
Breast pain/mass	NO	YES	Explain: _____
Menstrual problems	NO	YES	Explain: _____

Current Medications

Name: _____ Date: _____

Please include all prescriptions, over the counter medications, vitamins, and supplements.

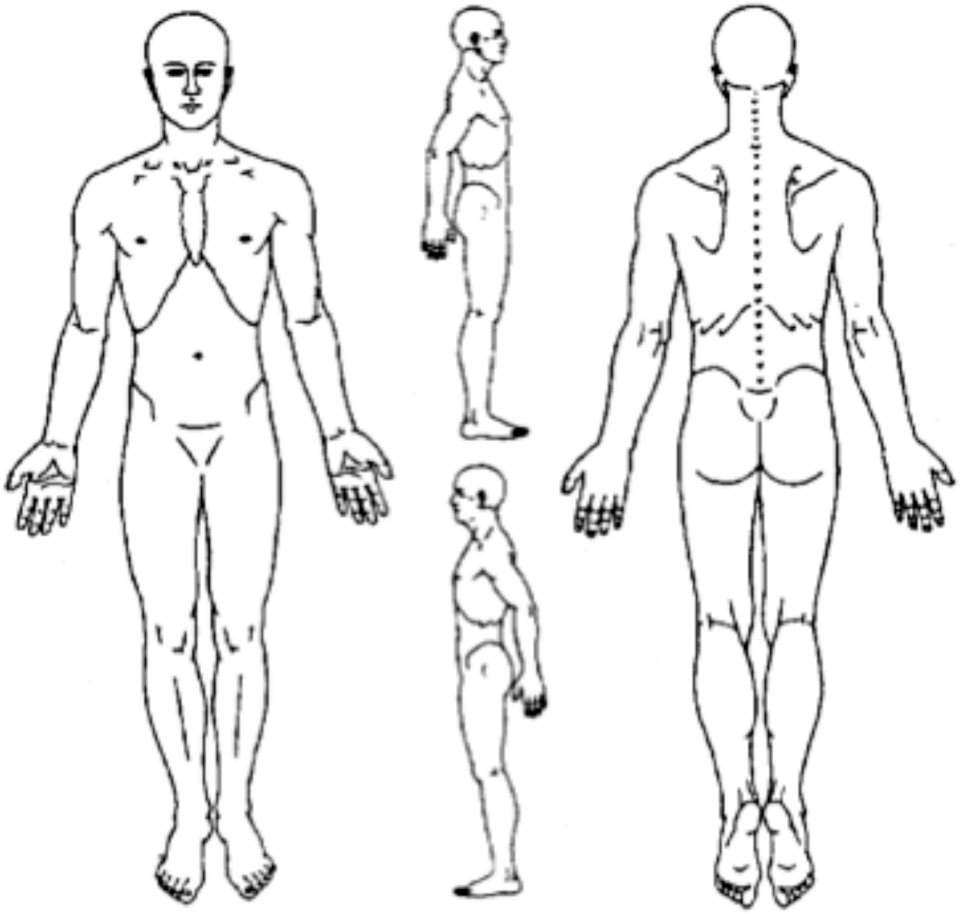
Medication Name	Dosage

Pain Diagram

Name: _____ Date: _____

Use the diagram and symbols below to indicate any pain or discomfort. Notate the intensity by using One (1) for mild pain to Ten (10) for the worst pain possible.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



Comments:_____

_____

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_____

_____