

# Patient Medical History

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Present complaint: \_\_\_\_\_  
\_\_\_\_\_

Other health care providers you are seeing, and their specialties: \_\_\_\_\_  
\_\_\_\_\_

First noticed? \_\_\_\_\_

Occupation: \_\_\_\_\_

No. of children \_\_\_\_\_

Religion (optional): \_\_\_\_\_

Have you been exposed to toxic chemicals? \_\_\_\_\_

If yes, which ones? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What diagnosis(s) were you given? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Women only** (next two lines):

Age at onset of menstruation: \_\_\_\_\_

Number of children: \_\_\_\_\_

No. of miscarriages/c-sections: \_\_\_\_\_

Age at onset of menopause: \_\_\_\_\_

How was your health as a child? (circle one):    excellent          good          fair          poor

Were there any complications with your delivery? Please explain: \_\_\_\_\_

Were you breast fed? \_\_\_\_\_ How long? \_\_\_\_\_

Did you have any serious emotional or mental traumas as a child? Please explain: \_\_\_\_\_

Check diseases for which you have been immunized:

measles    mumps    rubella    small pox    influenza    tetanus    diphtheria    other \_\_\_\_\_

What is your blood type? (circle one):    **A**          **B**          **AB**          **O**          **don't know**

Serious Illnesses / Injuries / Surgeries	Date	Outcome

Allergies / Sensitivities (Please Specify)	Typical Reaction
Animal hair/dander:	
Chemicals:	
Drugs, medications:	
Dust, molds:	
Food:	
Grasses, weeds, pollen:	
Others:	

**Tests History**

Please list the date of your most recent procedures. Circle any tests that were abnormal:

Test	Year	Test	Year	Test	Year	Test	Year
<input type="checkbox"/> Chest x-ray		<input type="checkbox"/> TB Test		<input type="checkbox"/> Pap Smear		<input type="checkbox"/> Others:	
<input type="checkbox"/> Kidney x-ray		<input type="checkbox"/> EKG		<input type="checkbox"/> Mammogram			
<input type="checkbox"/> G.I. Series		<input type="checkbox"/> MRI		<input type="checkbox"/> Sigmoidoscopy			
<input type="checkbox"/> Colon x-ray		<input type="checkbox"/> CAT Scan		<input type="checkbox"/> Rectal Exam			
<input type="checkbox"/> Spine x-ray		<input type="checkbox"/> Cardiac Stress Test		<input type="checkbox"/> PSA			
<input type="checkbox"/> Blood Tests		<input type="checkbox"/> Cholesterol		<input type="checkbox"/> Complete Physical Exam			

**Health Habits** (Please print clearly)

Please list all supplements / herbs / homeopathics you are currently taking (attach a separate sheet if necessary):

Type (include brand name)	Dosage

Please circle any of the following medications you are currently taking or have taken within last 3 months:

- |                         |                     |                      |                  |
|-------------------------|---------------------|----------------------|------------------|
| Allergy medication      | Chemotherapy        | Oral Contraceptives  | Ulcer Medication |
| Antacids                | Cortisone           | Pain Medication      | Other _____      |
| Anti-inflammatory       | Heart Medications   | Radiation            | _____            |
| Antibiotic /Anti-fungal | High Blood Pressure | "Recreational" Drugs | _____            |
| Antidepressants         | Hormones            | Relaxants            | _____            |
| Anti-diabetic/insulin   | Laxatives           | Sleeping Pills       | _____            |
| Aspirin/Tylenol / Advil | Lithium             | Thyroid              |                  |

**Do you:**

(Circle day or week, as appropriate):

- |  |                            |                       |
|--|----------------------------|-----------------------|
| <input type="checkbox"/> Use tobacco               | _____ packs per day/week   | How Many Years? _____ |
| <input type="checkbox"/> Drink coffee              | _____ cups per day/week    |                       |
| <input type="checkbox"/> Drink black tea           | _____ cups per day/week    |                       |
| <input type="checkbox"/> Drink alcohol             | _____ cups per day/week    |                       |
| <input type="checkbox"/> Drink sodas               | _____ cups per day/week    |                       |
| <input type="checkbox"/> Use artificial sweeteners | _____ packets per day/week |                       |
| <input type="checkbox"/> Use margarine             | _____ pats per day/week    |                       |

How many times a week do you eat in a restaurant? Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_

What types of restaurants? \_\_\_\_\_

What are your favorite foods: \_\_\_\_\_

Do you crave sweets? \_\_\_\_\_ At what time?: \_\_\_\_\_ Do you salt your food at the table? \_\_\_\_\_

Are there other foods you crave? (Please Circle) Bread Pasta Dairy Meat Other: \_\_\_\_\_

What foods do you really dislike: \_\_\_\_\_

Are you on any specific diet? If so, please specify: \_\_\_\_\_

Would you like to increase or decrease your weight? If so, by how much: \_\_\_\_\_

When did you last have a significant (more than 10 pounds) change in weight? \_\_\_\_\_

What exercise do you do and how often? \_\_\_\_\_

How many hours of sleep do you get each night? \_\_\_\_\_ Do you wake rested? \_\_\_\_\_

Are you presently sexually active? \_\_\_\_\_ Any difficulties? \_\_\_\_\_ Method of B.C.? \_\_\_\_\_

Rate your current stress level from 1-10: \_\_\_\_\_ How much does this affect you (1-10)? \_\_\_\_\_

What are the major stress factors in your life now? \_\_\_\_\_

Rate your current emotional health (circle): excellent good fair poor unstable crisis

Are you currently in psychotherapy? \_\_\_\_\_ Do you have a good support network/team? \_\_\_\_\_

Does your home environment have a supportive effect on your health? \_\_\_\_\_

How many hours of relaxation (not including sleep) do you give yourself during the work week? \_\_\_\_\_

During weekends? \_\_\_\_\_ Favorite recreational activities? \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_ Do you wear contacts? \_\_\_\_\_ Hard or soft? \_\_\_\_\_

Do you drink purified or bottled water? \_\_\_\_\_ If so, what brand do you use? \_\_\_\_\_

Do you have an air purifier in the room you sleep in? \_\_\_\_\_ What brand? \_\_\_\_\_

Do you have amalgam (silver) fillings? \_\_\_\_\_ Any other dental problems? \_\_\_\_\_

Do you make an effort to eat organically grown foods? \_\_\_\_\_ What % of your diet? \_\_\_\_\_

Are you on a restricted diet? Please explain: \_\_\_\_\_

Are you considering any elective surgery or medical procedures in the near future? \_\_\_\_\_

## Family Health History

Relation	Age	State Of Health (if living)	Age At Death	Cause of Death	Check (x) if your blood relatives have/had:	
					Disease	Relationship
Father					Arthritis, gout	
Mother					Asthma, hay fever	
Brothers					Cancer	
					Chemical dependency	
					Diabetes	
					Heart disease, stroke	
Sisters					High blood pressure	
					Syphilis, gonorrhea	
					Tuberculosis	
					Other	

## Diet Survey

Please list everything you eat and drink for 2-3 days:

Time	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

# Health and Lifestyle Overview

Please tell me what is bothering you. If this involves a specific health condition or illness, please tell me about it in as much detail as possible. List the very first time that you noticed the condition and describe carefully any factors that you think may have played a role in its onset and progression. (Please attach a sheet if more space is required).

Is your health currently getting better, worse, or staying the same. How do you know?

What have you tried to do to improve your state of health (e.g. other doctors, treatments, etc)?

Please list the 5 most significant stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

- a.
- b.
- c.
- d.
- e.

Please list any other health concerns/conditions, even if you think they may not be important.