Health Information
General Information:
Full Name:____
Preferred Name: ____
Date of Birth: ______/_______/________ **Age:**_______________ **Gender**_________________
Genetic Background:____
Highest Education Level:____
Job Title: ________________________ **Nature of Business:**______________________________
Referred by: ____

Allergies:____
What type reaction to each? ____

Concerns:
What do you hope to achieve in your visit with us?_____________________________________
____
____
If you had a magic wand and could erase three problems, what would they be?
1. ____
2. ____
3. ____

When was a the last time you felt well?____
____
Did something trigger your change in health?____
____
What makes you feel worse? ____
____
What makes you feel better?____
____
Please list current and ongoing problems in order of priority/severity/prior treatments:
1. ____
____
2. ____
____
3. ____
____
4. ____
____
5. ____
____

Diseases/Diagnoses/Conditions:
Please indicate with ‘p’ past, ‘o’ ongoing, with DATE of ONSET.

Gastrointestinal
Irritable Bowel Syndrome
Inflammatory Bowel Disease
Crohn’s
Ulcerative Colitis
Gastritis or Peptic Ulcer Disease
GERD/Reflux
Celiac Disease
Other

Genital & Urinary System
Kidney Stones
Gout
Interstitial Cystitis
Frequent Urinary Tract Infections
Frequent Yeast Infections
Erectile or Sexual Dysfunction
Other

Cardiovascular
Heart Attack
Other Heart Disease
Stroke
Elevated Cholesterol
Arrhythmia (irregular heart beat)
Hypertension (high blood pressure)
Rheumatic Rever
Mitral Valve Prolapse

Cancer
Lung CA
Breast CA
Colon CA
Ovarian CA
Prostate CA
Skin CA (non-melanoma)
Malignant Melanoma

Musculoskeletal
Osteoarthritis
Fibromyalgia
Chronic Pain
Other

Metabolic/Endocrine
Type I Diabetes
Type II Diabetes
Hypoglycemia
Metabolic Syndrome
Hypothyroidism (low thyroid)
Hyperthyroidism (high thyroid)
Endocrine Problems
PCOS
Infertility
Weight Gain
Weight Loss
Frequent Weight Fluctuations
Bulimia
Anorexia
Binge Eating Disorder
Night Eating Syndrome
Eating Disorder (no-specific)
Other

Inflammatory/Autoimmune
Chronic Fatigue Syndrome
Autoimmune Disease
Rheumatoid Arthritis
Lupus/SLE
Immune Deficiency Disease
Herpes-Genital
Sever Infectious Disease
Frequent Infections
Food Allergies
Environmental Allergies
Multiple Chemical Sensitivities
Latex Allergy
Other

Skin Disease
Eczema
Psoriasis
Acne
Melanoma
Skin Cancer
Other

Respiratory Disease
Asthma
Chronic Sinusitis
Injuries - AND DATES
Back Injury
Neck Injury
Head Injury
Broken Bones
Other

____

Bronchitis
Emphysema
Pneumonia
Tuberculosis
Sleep Apnea
Other

Neurological
Depression
Anxiety
Bipolar Disorder
Schizophrenia
Headaches
Migraines
ADD/ADHD
Autism
Mild Cognitive Impairment
Memory Problems
Parkinson’s Disease
Multiple Sclerosis
ALS
Seizures
Other Neurological Problems

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Surgery	check if had procedure	DATE
Appendectomy		
Hysterectomy +/- ovaries		
Hernia		
Tonsillectomy		
Dental Surgery		
Joint Repair		
Joint Replacement		
Heart Surgery - valve		
Heart Surgery/ Bypass		
Other		

Hospitalization History with Dates

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Preventive & Other Tests / Dates
Full Physical Exam______________________
Bone Density__________________________
Colonoscopy__________________________
Cardiac Stress Test_____________________
Heart Scan____________________________
EKG_________________________________
Hemoccult/Stool blood___________________
MRI__________________________________
CT Scan______________________________
Upper Endoscopy_______________________
Upper GI Series________________________
Ultrasound____________________________

Gynecological History (for women only)
OBSTETRIC HISTORY
Number of Pregnancies___Vaginal Deliveries___ Caesarian___Miscarriages____Abortions___
Number of Living Children and ages ____
Post Partum Depression and dates_________________ Toxemia and dates_________________
Gestational Diabetes_______Baby over 8 #________Breastfeeding for how long?__________
Menstrual History
Age first period_______Menses Frequency______Length________ Pain: Yes/No Clots: Yes/No
Has your period ever skipped?__________How often?__________How long?______________
First Day of Last Menstrual Period:_________________ Using Contraception? Yes/No
Form of Contraception: Condom___Diaphragm_____IUD_____Partner Vasectomy_________
Have you used: Birth Control Pills________ Patch_______ NuvaRing_____ How Long?_____
Hormonal Imbalances
(circle all that apply) Fibrocystic Breasts Endometriosis Fibroids Infertility
Painful Periods Heavy Periods PMS
Last Mammogram____________Normal?_________ Breast Biopsy/Date_________________
Last PAP_________HPV_______ All normal PAP history?______________________________
Last DEXA/bone density date and result____
Age at Menopause _______________________
(circle all that apply) Hot flashes Mood Swings Concentration/Memory Problems
Palpitations Vaginal Dryness Decreased Libido Heavy Bleeding Joint Pains
Headaches Weight Gain Loss of Urine Control Use of Hormone Replacement Therapy

Men's History (for men only)
Have you had a PSA level? Results and dates ____
(circle all that apply) Prostate Enlargement Prostate Infection Change in Libido
Impotence Difficulty Obtaining an Erection Difficulty Maintaining an Erection
Nocturia (urinating at night) - how many times?______ Loss of Control of Urine
Urgency/Hesitancy/Change in Urinary Stream

GI History
Please list foreign travel (location and dates):
____
____
____
____
____
Wilderness Camping? Where/When
____
____
Have you ever had severe: Gastroenteritis_______________ Diarrhea_____________________
Do you feel like you digest your food well?____
Do you feel bloated after meals?____

Patient Birth History
Were you born on time/term?_______Premature_______ Vaginal Delivery or C-Section_______
Any pregnancy complications?____
Any birth complications?____
Did you remain in the hospital after birth or the NICU?_____ How Long?___________________
Were you breast fed?__________How long?_________ Bottle fed?_______________________
Age at introduction of: Solid Foods:___________Dairy:___________Wheat:_______________
Did you eat much sugar as a child?________________Processed foods?_________________

Dental History
Do you have silver mercury fillings?_______How many?_______ Age placed_______________
Have you had any amalgams removed?_______When?_______With Biological Dentist?______
Do you floss regularly?___________ How often?_______Dental cleaning frequency_________
(circle all that apply) Gold Fillings Root Canals Implants Bleeding Gums
Gingivitis Problems Chewing

Current Medications	Dose	Frequency	Start Date	Reason for Use

Previous Medications	Dose	Frequency	Start/Stop Dates	Reason for Use & Discontinuation

Nutritional Supplements	Dose	Frequency	Start Date	Reason for Use

Have your medications or supplements ever caused you unusual side effects? Describe:
____
____
Have you had prolonged or regular use of NSAIDS (Advil, Aleve, Motrin, Aspirin)?____________
Have you had prolonged or regular use of Tylenol/Acetaminophen?________________________
Have you had prolonged or regular use of acid blocking drugs? (Tagamet, Zantac, Prilosec, Prevacid)____
Frequent Antibiotics?___________Long term antibiotics at any time?________________________
Use of steroids (prednisone, nasal allergy inhalers) in the past?_______recurrently?_________