

# Health History

**CONFIDENTIAL**

## Habits

- Smoking Packs / day \_\_\_\_\_
- Alcohol Drinks / week \_\_\_\_\_
- Coffee Cups / day \_\_\_\_\_
- Sodas Cups / week \_\_\_\_\_

## Exercise

- None Never have regularly\_\_\_\_, # Years since\_\_\_\_\_
- Occasional How often\_\_\_\_, duration (min)\_\_\_\_, Since\_\_\_\_\_
- Weekly # / Week\_\_\_\_, duration\_\_\_\_, Since\_\_\_\_\_
- Daily # Minutes\_\_\_\_, since when\_\_\_\_\_

## Family History (please record conditions experienced by family members and cause of death, when applicable)

	Diabetes	Cancer	Heart	^Bld. Pres.	^Chol.	Kidney	Scoliosis	Back probs	Depression	"Nerves"	Cause of Death ( when applicable)
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

## Have you had any of the following diseases?

- 541 Appendicitis  285.9 Anemia  429.9 Heart Disease  716.9 Arthritis Osteo\_\_\_\_ Rheumatoid\_\_
- 541 Pneumonia  285.9 Measles  429.9 Goiter  716.9 Epilepsy
- 541 Rheumatic Fever  285.9 Mumps  429.9 Influenza  716.9 Mental Disorder
- 541 Polio  285.9 Chicken Pox  429.9 Pleurisy  716.9 Low Back Pain
- 541 Tuberculosis  285.9 Diabetes  429.9 Alcoholism  716.9 Eczema
- 541 Whooping Cough  285.9 Cancer  429.9 Venereal Infection  Aids

## Have you ever experienced any of the following symptoms?

Often seemingly unrelated complaints that you might not think to mention indicate a pattern in the bigger picture of Holistic Health  
Please grade accordingly: 1 = Previously experienced 2 = Occasionally experience 3 = Presently experience 4 = Presently Severe

## General Symptoms

- \_\_\_784.0 Headache
- \_\_\_780.6 Fever
- \_\_\_780.9 Chills
- \_\_\_780.8 Night Sweats
- \_\_\_780.2 Fainting
- \_\_\_780.4 Dizziness
- \_\_\_780.3 Convulsions
- \_\_\_780.52 Loss of Sleep
- \_\_\_780.7 Fatigue
- \_\_\_799.2 Nervousness
- \_\_\_783 Loss of Weight
- \_\_\_782 Numbness or pain in Arms / Legs / Hands
- \_\_\_995.3 Allergy\_\_\_\_\_
- \_\_\_786.09 Wheezing
- \_\_\_729.2 Neuralgia

## Gastro-intestinal

- \_\_\_783 Poor Appetite
- \_\_\_536.8 Poor Digestion
- \_\_\_994.2 Excessive Hunger
- \_\_\_787.3 Belching or Gas
- \_\_\_787 Nausea
- \_\_\_787 Vomiting
- \_\_\_578 Vomiting Blood
- \_\_\_536.8 Pain over Stomach
- \_\_\_564 Constipation
- \_\_\_558.9 Diarrhea
- \_\_\_789 Colon Trouble
- \_\_\_455.6 Hemorrhoids (piles)
- \_\_\_785.1 Liver Trouble
- \_\_\_782.4 Jaundice
- \_\_\_575.9 Gall Bladder Trouble
- \_\_\_ Abnormal Stool
- \_\_\_ Gastritis / Ulcer

## Eye/Ear/Nose/Throat

- \_\_\_368.9 Poor Vision
- \_\_\_378.9 Crossed Eyes
- \_\_\_379.91 Pain in Eyes
- \_\_\_389.9 Deafness
- \_\_\_388.70 Earache
- \_\_\_388.30 Ear Noises (tinnitus)
- \_\_\_388.60 Ear Discharges
- \_\_\_478.1 Nasal Obstruction
- \_\_\_784.7 Nose Bleeds
- \_\_\_462 Sore Throats
- \_\_\_784.49 Hoarseness
- \_\_\_477.9 Hay Fever
- \_\_\_493.9 Asthma
- \_\_\_460 Frequent Colds
- \_\_\_240.9 Enlarged Thyroid
- \_\_\_463 Tonsillitis
- \_\_\_686.9 Sinus Trouble

## Respiratory

- \_\_\_786.2 Chronic Cough
- \_\_\_786.3 Spitting Blood
- \_\_\_933.1 Spitting Phlegm
- \_\_\_786.50 Chest Pain
- \_\_\_786.09 Difficulty Breathing
- \_\_\_ Bronchitis :Chronic Y / I

## Genito-Urinary

- \_\_\_788.3 Frequent Urination
- \_\_\_788.1 Painful Urination
- \_\_\_599.7 Blood in Urine
- \_\_\_592 Kidney Infection
- \_\_\_788.3 Bed Wetting
- \_\_\_788.1 Inability to control urine
- \_\_\_601.9 Prostate Trouble

## Muscles & Joints

- \_\_\_ Weakness
- \_\_\_ Twitching
- \_\_\_847 Stiff Neck
- \_\_\_722.10 Backache
- \_\_\_719 Swollen Joints
- \_\_\_781 Tremors
- \_\_\_729.5 Foot Trouble
- \_\_\_724.79 Painful Tail Bone
- \_\_\_724.5 Pain Between Shoulders
- \_\_\_563.3 Hernia
- \_\_\_737.3 Spinal Curvature

## Cardiovascular

- \_\_\_783 Rapid Heart
- \_\_\_427.89 Slow Heart
- \_\_\_401.9 High Blood Pressure
- \_\_\_458.9 Low Blood Pressure
- \_\_\_786.51 Pain over Heart
- \_\_\_438 Previous Heart Trouble
- \_\_\_719.07 Swelling Ankles
- \_\_\_759.9 Poor Circulation
- \_\_\_ Varicose Veins
- \_\_\_436 Strokes

## Skin or Allergies

- \_\_\_368.9 Skin Eruptions
- \_\_\_698.9 Itching
- \_\_\_278.8 Bruising Easily
- \_\_\_701.1 Dryness
- \_\_\_ Boils
- \_\_\_782 Sensitive Skin
- \_\_\_708.9 Hives or Allergies
- \_\_\_692.9 Eczema
- \_\_\_ Psoriasis

## Female Conditions

- \_\_\_786.2 Painful Periods
- \_\_\_626.2 Excessive Flow
- \_\_\_626.4 Irregular Cycle
- \_\_\_627.2 Hot Flashes
- \_\_\_625.3 Cramps or Backache
- \_\_\_634.9 Miscarriage
- \_\_\_623.5 Vaginal Discharge
- \_\_\_ Vaginal Yeast infection
- \_\_\_ Currently Pregnant

By Whom \_\_\_\_\_  
Last Pap (date) \_\_\_\_\_  
Other \_\_\_\_\_

# Operations and Procedures

Date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Vaccinations  
Tonsillectomy  
Gall Bladder  
Back Operation

Date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Tubes in Ears  
Appendectomy  
Female Organs  
Rectal Surgery

Date

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Sinus  
Hernia  
Thyroid  
Stomach

Other: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

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List any accidents or falls and dates:  Car \_\_\_\_\_  Recreational Vehicle \_\_\_\_\_  
 Sports \_\_\_\_\_  School \_\_\_\_\_  Other (including childhood, falls, etc.) \_\_\_\_\_

List any broken bones (fractures) or dislocations: \_\_\_\_\_

Ever on crutches?  No  Yes Why? \_\_\_\_\_

Have you ever been knocked unconscious?  No  Yes Explain: \_\_\_\_\_

Have you ever had a lapse of memory?  No  Yes Explain: \_\_\_\_\_

Have you ever had a spinal tap or spinal injection?  No  Yes Explain: \_\_\_\_\_

Have you ever had X-Rays taken?  No  Yes Please list when, why and by whom: \_\_\_\_\_

Do you suffer from any condition other than that for which you are now consulting us?  No  Yes

Please list all medications (prescription & over the counter) you are currently taking, dosage, reason for taking and who prescribed or suggested them.

Please list all vitamin, mineral, herbal, homeopathic or other preparations you are currently taking, dosage, reason for taking who prescribed or suggested them.

Please list all known and suspected allergies. \_\_\_\_\_

How is your diet?

(whole grains \_\_\_\_\_%, fresh vegetables \_\_\_\_\_%, nuts & seeds \_\_\_\_\_%, fresh fruits \_\_\_\_\_%, dairy \_\_\_\_\_%, white meats \_\_\_\_\_%, red meats \_\_\_\_\_%, canned food \_\_\_\_\_%, frozen food \_\_\_\_\_%, fat \_\_\_\_\_%)

In your opinion how is your general health? \_\_\_\_\_

How well do you sleep and in what position(s)? \_\_\_\_\_

What level of lifestyle stress would you estimate you have? \_\_\_\_\_