Health History

Habits

Smoking Packs/Day _____
Alcohol Drinks/Week _____
Coffee Cups/Day _____
Sodas Cups/Week _____

Exercise

None Never have since _____
Occasional How often, Since?_____
Weekly #/Week, Since?_____
Daily How long, Since?_____

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

	Diabetes	Cancer	Heart	Bld. Pres.	Chol.	Kidney	Scoliosis	Back Problems	Depression	Nerves	Cause of Death
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Brother (s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
Sister (s)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____

Have you ever had any o f the following?

☐ 541 Appendicitis ☐ 285.9 Anemia ☐ 285.9 Cancer ☐ 429.9 Heart Disease
☐ 541 Pneumonia ☐ 285.9 Measles ☐ 716.9 Epilepsy ☐ 716.9 Arthritis
☐ 541 Rheumatic Fever ☐ 285.9 Mumps ☐ 429.9 Influenza ☐ 716.9 Mental Disorder
☐ 541 Polio ☐ 285.9 Chicken Pox ☐ 716.9 Low Back Pain ☐ Aids
☐ 541 Tuberculosis ☐ 285.9Diatbetes ☐ 429.9 Alcoholism ☐ 716.9 Eczema
☐ 541 Whooping Cough

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

General Symptoms	1	2	3	4
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 of Arms/ Legs / Hands	☐	☐	☐	☐
995.3 Allergy_____	☐	☐	☐	☐
786.9 Wheezing	☐	☐	☐	☐

Gastro-intestinal	1	2	3	4
783 Poor Appetite	☐	☐	☐	☐
536.8 Poor Digestion	☐	☐	☐	☐
787.3 Belching or Gas	☐	☐	☐	☐
787 Nausea / Vomiting	☐	☐	☐	☐
578 Vomiting Blood	☐	☐	☐	☐
564 Constipation	☐	☐	☐	☐
558.9 Diarrhea	☐	☐	☐	☐
789 Colon Trouble	☐	☐	☐	☐
455.6Hemorrhoids	☐	☐	☐	☐
785.1 Liver Trouble	☐	☐	☐	☐
782.4 Jaundice	☐	☐	☐	☐
575.9 Gall Bladder	☐	☐	☐	☐
Abnormal Stool	☐	☐	☐	☐
Gastritis / Ulcer	☐	☐	☐	☐

Eye/Ear/ Nose/ Throat	1	2	3	4
368.9 Poor Vision	☐	☐	☐	☐
378.9 Crossed Eyes	☐	☐	☐	☐
379.91 Pain in Eyes	☐	☐	☐	☐
389.9 Deafness R/L	☐	☐	☐	☐
388.70 Earache	☐	☐	☐	☐
388.30 Ear Noises (tinnitus)	☐	☐	☐	☐
388.60 Ear Discharges	☐	☐	☐	☐
784.7 Noise Bleeds	☐	☐	☐	☐
462 Sore Throats	☐	☐	☐	☐
784.49 Hoarseness	☐	☐	☐	☐
477.9 Hay Fever	☐	☐	☐	☐
493.9 Asthma	☐	☐	☐	☐
460 Frequent Colds	☐	☐	☐	☐
463 Tonsillitis	☐	☐	☐	☐
	☐	☐	☐	☐

Muscles & Joints	1	2	3	4
_____Weakness	☐	☐	☐	☐
_____Twitching	☐	☐	☐	☐
847 Stiff Neck	☐	☐	☐	☐
462 Sore Th roats	☐	☐	☐	☐
722.10 Backache	☐	☐	☐	☐
719 Swollen Joints	☐	☐	☐	☐
781 Tremors	☐	☐	☐	☐
729.5 Foot Trouble	☐	☐	☐	☐
563.3 Hernia	☐	☐	☐	☐
737.3 Spinal Curvature	☐	☐	☐	☐
724.5 Pain Between Shoulders	☐	☐	☐	☐

Cardiovascular	1	2	3	4
783 Rapid Heart	☐	☐	☐	☐
427.89 Slow Heart	☐	☐	☐	☐
401.9 High Blood Pres.	☐	☐	☐	☐
458.9 Low Blood Pressure	☐	☐	☐	☐
786.51 Pain over Heart	☐	☐	☐	☐
438 Previous Heart Trouble	☐	☐	☐	☐
719.07Swelling Ankles	☐	☐	☐	☐
759.9 Poor Circulation	☐	☐	☐	☐
_____Varicose Veins	☐	☐	☐	☐
436 Stroke	☐	☐	☐	☐

Skin or Allergies	1	2	3	4
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	☐	☐	☐	☐
623.5 Vaginal Discharge	☐	☐	☐	☐

Continue to the Back Please!

Respiratory	1	2	3	4
786.2 Chronic Cough	☐	☐	☐	☐
786.3 Spitting Blood	☐	☐	☐	☐
933.1 Spitting Phlegm	☐	☐	☐	☐
786.50 Chest Pain	☐	☐	☐	☐
786.09 Difficulty Breathing	☐	☐	☐	☐
	☐	☐	☐	☐

Genito-Urinary	1	2	3	4
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	☐	☐	☐	☐

Female Conditions	1	2	3	4
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	☐	☐	☐	☐

For Women Only:

Are you Pregnant now? Y/N Due date_____

Have you been Pregnant in the Past? Y/N How many times and when?_____

Operations and Procedures

Date:		Date:		Date:	
_____	Vaccinations	_____	Tubes in Ear	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid
_____	Back Operation	_____	Rectal Surgery	_____	Stomach

Other:_____

Hospitalizations:_____

Please list any and all accidents and falls with the dates of each incident. (Car, Recreational Vehicle, Sports, School, Work, Childhood)_____

_____

_____

Have you ever broken a bone or had a dislocation? Y/N Explain:_____

_____

Have you ever been knocked unconscious? Y/N Explain:_____

_____

Have you ever had a laps of memory? Y/N Explain:_____

_____

Have you ever had a spinal tap or injection? Y/N Explain:_____

_____

Have you ever had an X-Ray? Y/N Explain When, Why, and By Whom:_____

_____

Please list any and all medications (prescription and over the counter) you are taking, dosage, reason for taking and who prescribed them._____

_____

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

_____

Please list all known allergies:_____

Please specify the % of each for the following in your daily diet:

_____Whole grains	_____Fresh Vegetables	_____Nuts &Seeds	_____Fresh Fruits	_____Dairy
_____White meat	_____Red Meat	_____Caned Food	_____Frozen Food	_____Fast Food

How well do you sleep and what position?_____

What level of lifestyle stress would you estimate you have?_____