

# 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 record 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	<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 ever had any of the following?

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> 541 Appendicitis    | <input type="checkbox"/> 285.9 Anemia      | <input type="checkbox"/> 285.9 Cancer        | <input type="checkbox"/> 429.9 Heart Disease   |
| <input type="checkbox"/> 541 Pneumonia       | <input type="checkbox"/> 285.9 Measles     | <input type="checkbox"/> 716.9 Epilepsy      | <input type="checkbox"/> 716.9 Arthritis       |
| <input type="checkbox"/> 541 Rheumatic Fever | <input type="checkbox"/> 285.9 Mumps       | <input type="checkbox"/> 429.9 Influenza     | <input type="checkbox"/> 716.9 Mental Disorder |
| <input type="checkbox"/> 541 Polio           | <input type="checkbox"/> 285.9 Chicken Pox | <input type="checkbox"/> 716.9 Low Back Pain | <input type="checkbox"/> Aids                  |
| <input type="checkbox"/> 541 Tuberculosis    | <input type="checkbox"/> 285.9 Diabetes    | <input type="checkbox"/> 429.9 Alcoholism    | <input type="checkbox"/> 716.9 Eczema          |
| <input type="checkbox"/> 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

<u>General Symptoms</u>	1	2	3	4	<u>Gastro-intestinal</u>	1	2	3	4	<u>Eye/Ear/Nose/Throat</u>	1	2	3	4
784.0 Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	783 Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	368.9 Poor Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
780.6 Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	536.8 Poor Digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	378.9 Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
780.9 Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787.3 Belching or Gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	379.91 Pain in Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
780.8 Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	787 Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	389.9 Deafness R/L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
780.2 Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	578 Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	388.70 Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
780.4 Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	564 Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	388.30 Ear Noises (tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
780.3 Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	558.9 Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	388.60 Ear Discharges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
780.52 Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	789 Colon Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	784.7 Noise Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
780.7 Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	455.6 Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	462 Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
799.2 Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	785.1 Liver Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	784.49 Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
783 Loss of Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	782.4 Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	477.9 Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
782 Numbness or pain of Arms/Legs/Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	575.9 Gall Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	493.9 Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
995.3 Allergy _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	460 Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
786.9 Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastritis/Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	463 Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Muscles &amp; Joints</u>	1	2	3	4	<u>Cardiovascular</u>	1	2	3	4	<u>Skin or Allergies</u>	1	2	3	4
____ Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	783 Rapid Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	368.9 Skin Eruptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
____ Twitching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	427.89 Slow Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	698.9 Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
847 Stiff Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	401.9 High Blood Pres.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	278.8 Bruising Easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
462 Sore Throats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	458.9 Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	701.1 Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
722.10 Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	786.51 Pain over Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
719 Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	438 Previous Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	782 Sensitive Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
781 Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	719.07 Swelling Ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	708.9 Hives or Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
729.5 Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	759.9 Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	692.9 Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
563.3 Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	____ Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	623.5 Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
737.3 Spinal Curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	436 Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
724.5 Pain Between Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										

Continue to the Back Please!

Respiratory

	1	2	3	4
786.2 Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
786.3 Spitting Blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
933.1 Spitting Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
786.50 Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
786.09 Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Genito-Urinary

	1	2	3	4
788.3 Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
788.1 Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
599.7 Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
592 Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
788.3 Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
788.1 Inability to Control Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
601.9 Prostate Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Female Conditions

	1	2	3	4
786.2 Painful Periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
626.2 Excessive Flow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
626.4 Irregular Cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
627.2 Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
625.3 Cramps or Backache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
634.9 Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
623.5 Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal Yeast infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: _____	Vaccinations	Date: _____	Tubes in Ear	Date: _____	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    \_\_\_\_\_ Canned Food    \_\_\_\_\_ Frozen Food    \_\_\_\_\_ Fast Food

How well do you sleep and what position? \_\_\_\_\_  
 What level of lifestyle stress would you estimate you have? \_\_\_\_\_  
 L Mos