Patient Health History

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Patient Name: _____ DOB: ____/____/____ Date: ____/____/____

Occupation: _____ How did you hear about us? _____

Current health problems:	Current medications / supplements:	Drug allergies:
1:	1:	1:
2:	2:	2:
3:	3:	3:
4:	4:	4:
5:	5:	5:

List other doctors / health professionals:

List surgeries / accidents / injuries / hospitalizations:

1:
2:
3:
4:
5:

Do you have any scars? Where?

Family disease history (Indicate self / family member):

Asthma:	Thyroid disease:
Arthritis:	Stroke:
Cancer:	Tuberculosis:
Diabetes:	Parkinson's:
Epilepsy/Seizures:	Alzheimer's:
Heart disease:	Multiple sclerosis:
High blood pressure:	Other:
Mental illness or depression:	

Describe past dental work:

List foods you eat for:

Breakfast:

Lunch:

Dinner:

Snacks:

List past immunizations:

List past significant illnesses:

List any known allergies or sensitivities (food and environmental):

Lifestyle / Diet (type, amount, frequency):

Smoke:
Exercise:
Caffeine / Soda pop:
Alcohol:
Sleep (good / bad):
Overall Stress level (low-moderate-high):

Have you ever been on any medication for more than a week? Describe:

Please check off **current** symptoms:

General:

- ☐ Alcoholism
- ☐ Anemia
- ☐ Cancer
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Epilepsy / Seizures
- ☐ Thyroid
- ☐ Gout
- ☐ Hypoglycemia
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Parkinson's Disease
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Depression
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Sexually Transmitted Infection
- ☐ Skin problems

Resistance to infection:

- ☐ Catch colds easily
- ☐ Gum bleed easily
- ☐ Frequent sinus trouble
- ☐ Frequent Influenza

Gastrointestinal:

- ☐ Gall bladder problems
- ☐ Liver trouble / Hepatitis
- ☐ Excessive thirst
- ☐ Distress from fats or greasy foods
- ☐ Pain over stomach
- ☐ Burping in stomach relieved by eating
- ☐ Burping or bloating, if bloating where? _____
- ☐ Heartburn
- ☐ Nausea
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Constipation
- ☐ Mucus in stool
- ☐ Colitis
- ☐ Hiatal Hernia
- ☐ Vomiting
- ☐ Recent weight loss
- ☐ Recent weight gain

Cardiovascular:

- ☐ Pain over heart
- ☐ Heart attack
- ☐ Swelling in ankles
- ☐ Irregular heart beat
- ☐ High blood pressure
- ☐ Shortness of breath on exertion
- ☐ Low blood pressure
- ☐ Stroke
- ☐ Pressure over chest

Nervous System:

- ☐ Dizziness / light-headed
- ☐ Fainting
- ☐ Discoordination
- ☐ Memory loss
- ☐ Strength or sensation loss

Eye, Ear, Nose and Throat:

- ☐ Vision problems
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Ear noises
- ☐ Hoarseness
- ☐ Dental problems
- ☐ Nose bleeding
- ☐ Difficult breathing through nose
- ☐ Sore throat
- ☐ Difficult speech

Musculoskeletal:

- ☐ Neck pain
- ☐ Low back pain
- ☐ Joint pain: _____

Urinary Tract:

- ☐ Blood in urine
- ☐ Inability to control urination
- ☐ Painful urination
- ☐ Bladder infection
- ☐ Kidney stones

Respiratory:

- ☐ Chest pain
- ☐ Spitting up blood
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Emphysema
- ☐ Asthma

Women Only:

- ☐ Irregular periods
- ☐ Menstrual cramps
- ☐ Spotting
- ☐ Excessive flow
- ☐ Headaches with period
- ☐ Painful breasts
- ☐ Lumps in breast
- ☐ Mastectomy
- ☐ Premenstrual depression
- ☐ Vaginal discharge
- ☐ Menopausal symptoms
- ☐ Hot flashes
- ☐ Nausea
- ☐ Hysterectomy

Men Only:

- ☐ Burning on urination
- ☐ Difficulty starting urine
- ☐ Need to get up at night to urinate
- ☐ Dripping after urination
- ☐ Prostate trouble

Blood Sugar:

- ☐ Irritable before meals
- ☐ Get "shaky" if hungry
- ☐ "Light-headed" if meals delayed
- ☐ Fatigue—eating relieves
- ☐ Heart palpitates if meals are missed / delayed
- ☐ Awaken after a few hours of sleep—hard to get back to sleep
- ☐ Moods of depression "blues" or melancholy
- ☐ Abnormal craving for sweets or snacks