



AFFORDABLE HOLISTIC FAMILY MEDICINE

Adult Health History

Personal Information

Name _____

Address _____

Phone (am) _____ Phone (pm) _____

E-mail address _____

Date of Birth _____ Age _____ Place of Birth _____

Ethnicity/Nationality _____

Religion/spiritual practice _____ Do you actively practice? Yes No

Height _____ Weight _____

Most you've weighed as an adult _____ year _____

Least you've weighed as an adult _____ year _____

Where and when have you lived or traveled outside the U.S.?

Occupation _____ For how long _____

How stressful (on a scale of 1-10) _____ Highest level of education obtained _____

Marital status: Single Partnered Married Widowed Divorced

Number of times divorced _____

Children: Names and ages _____

Partner's name _____

Partner's occupation _____

Emergency contact (Name/Address/Phone) _____

What concerns would you like to address? Please indicate how long they have been going on.

1. _____

2. _____

3. _____

In order to heal these conditions, are you willing to make changes in your lifestyle if necessary? _____

Is another health care practitioner currently treating you? _____

Last Physical exam _____ Last dental exam _____

What other health related issues have you had in the past? Please include hospitalizations and surgeries

Year/Condition _____

Year/Condition _____

Year/Condition _____

Family History

	Father	Mother	Sisters	Brothers	Children
Age (living)					
Illnesses					
Age at death (if died)					

Please circle any illnesses that you have had yourself or that have occurred in any of your blood relatives. Please indicate S for self and O for other. If known, please indicate who and at what age the illness occurred.

- | | | |
|-------------------------|----------------------------|----------------------|
| Diabetes | Scarlet or Rheumatic Fever | Anemia |
| Thyroid problems | Hepatitis A, B or C | Arthritis |
| High/Low blood pressure | Gout | AIDS |
| Hemophilia | Venereal disease | Depression |
| Mental Illness | Lung disease | Addiction (any kind) |
| Stroke | Heart Disease | Eating disorder |
| Kidney Disease | Tuberculosis | Epilepsy/Seizures |
| Asthma, Allergies | Glaucoma/Cataracts | |
| Cancer, what type _____ | | Other _____ |

Diet and Nutrition

Please list the times you eat and the types of foods you would eat for a typical....

Breakfast _____ at ___ o'clock

Lunch _____ at ___ o'clock

Dinner _____ at ___ o'clock

Snack _____ at ___ o'clock

What foods do you crave? _____

What foods do you react poorly or are allergic to? _____

How many glasses of water do you drink every day? _____

Do you use any of the following now or have you in the past? If so, what type? Amount each day? For how long?

Tobacco _____ Alcohol _____

Coffee/ black tea _____ Soda/carbonated beverages _____

Recreational drugs _____

Lifestyle

How is your stress level? High___ Average___ Low___ Major Stresses_____

Do you have allergies or sensitivities to medications or other substances? Yes No

Please list _____

Do you have allergies or sensitivities to any chemicals or environmental toxins? Yes No

Please list _____

What happens to you when you have an "allergy attack?" _____

What prior types of allergy testing have you had? _____

Current Medications

Please list medications you are currently using including prescription, over the counter, herbal and vitamins. Please include how long you have been using them.

Immunizations Please mark if you have received any of the following:

Polio Chicken pox Smallpox TB Measles Mumps Rubella Diptheria

Pertussis Tetanus Flu/Influenza Hepatitis, A or B Meningococcus

Other _____

Any history of reactions to vaccinations? Yes No

If yes, please explain _____

Exercise

Do you exercise regularly? Yes No

Please list typical weekly exercise (type of exercise and how often per week)

List of Symptoms This list may seem redundant but it does help us to guide our recommendations and treatment. Please check any symptoms that have occurred in the past month.

MENTAL/EMOTIONAL

- Mood swings/depression
- Eating disorder
- Tension
- Anxiety or nervousness
- Seasonal depression
- Considered/attempted suicide

ENDOCRINE

- Thyroid problems
- Heat or cold intolerance
- Fatigue
- Hypoglycemia
- Excess thirst or hunger
- Diabetes

IMMUNE

- Chronic fatigue syndrome
- Chronically swollen glands
- Chronic infections
- Frequent colds
- Autoimmune disease
- Allergies or hay fever

NEUROLOGIC

- Seizures
- Vertigo or dizziness
- Paralysis
- Numbness or tingling
- Loss of memory
- Loss of balance

SKIN

- Rashes
- Color change
- Eczema
- Fungus
- Itching
- Acne or boils

HEAD

- Headaches
- Migraines
- Head Injury
- Jaw/TMJ problems

RESPIRATORY

- Cough
- Pain with breathing
- Wheezing or asthma
- Shortness of breath
- Bronchitis
- Spitting up blood

MOUTH AND THROAT

- Teeth grinding
- Hoarseness
- Copious saliva
- Dry mouth
- Gum problems
- Sore tongue or lips
- Frequent sore throat
- Mouth sores

URINARY/KIDNEY

- Pain on urination
- Increased frequency
- Frequency at night
- Kidney stones
- Infections
- Urine leakage

REPRODUCTIVE

- Pain with intercourse
- Sexually transmitted infection
- Sexual difficulties
- Discharge or sores
- Trouble conceiving
- Discharge

FEMALE ONLY

- Length of cycle (days)
- How many days of bleeding?
- Are cycles regular?
- Heavy periods
- Painful menses
- Bleeding between cycles
- PMS
- Clotting
- Abnormal paps
- Age at first menses

NOSE AND SINUSES

- Stuffiness
- Nose Bleeds
- Hay fever
- Sinus problems
- Loss of smell
- Sinus headaches

EYES

- Floaters or 'spots'
- Cataracts
- Blurriness
- Double Vision
- Glaucoma
- Near/Far sightedness
- Tearing or dryness
- Eye pain/strain
- Impaired vision

CARDIOVASCULAR

- Heart disease
- Murmurs
- Chest pain
- Poor circulation
- Blood clots
- Deep leg pain
- Valvular problems

GASTROINTESTINAL

- Trouble swallowing
- Nausea
- Vomiting
- Diarrhea
- Belching
- Passing gas

- Nipple discharge
- Breast lumps or pain
- Ovarian cysts
- Endometriosis
- Infertility
- Menopausal symptoms
- # of pregnancies
- # of live births
- # of miscarriages
- # of abortions

EARS

- Impaired hearing
- Earaches
- Ringing

MUSCULOSKELETAL

- Joint pain
- Joint stiffness
- Arthritis
- Weakness
- Sciatica
- Broken bones
- Muscle pain
- Muscle spasm
- Osteoporosis
- Palpitations
- Easy bruising
- Anemia
- Varicose veins
- Fainting
- Swelling in ankles

HEARTBURN

- Heartburn
- Change in thirst/appetite
- Abdominal pain or cramps
- Hemorrhoids
- Blood in toilet
- Black stool

MALE ONLY

- Testicular mass
- Testicular pain
- Prostate disease
- Hernia
- Impotence
- Premature ejaculation

How did you hear about us? _____

In a few words, what do you hope for in this treatment? _____

How long do you think it should last? _____

Have you used alternative medicine in the past? Yes No

If yes, for what concern? _____