## Health History

Name: _____ Date: _____

Main concern or reason(s) for seeing the doctor:

_____

_____

_____

## Personal

Major Illnesses (please give types and dates):

_____

_____

_____

Previous hospitalizations or surgeries:

_____

_____

Allergies:

_____

## Family

Please list any major illnesses for the following BLOOD relatives:

Father:_____

Mother:_____

Siblings:_____

Other:_____

## Social

Current Smoker? NO YES Past Smoker? NO YES Quit date:_____

If "yes" for either, how often and for how long?_____

Alcohol Consumption YES NO

If "yes", how often and how much? _____

Occupation: _____

Toxic Exposure: _____

## Wellbeing

Name: _____ Date: _____

What are your health goals?

_____

_____

_____

What practices and/or activities do you use to sustain your health and wellbeing (religious, spiritual, what inspires you, etc.)? _____

_____

_____

Who do you turn to for support? _____

What causes you stress? _____

Who lives with you? _____

## Health Issues

What do you think causes (caused) your health issues? _____

_____

How do(es) your health issue(s) effect you? _____

_____

How severe is the issue? How long do you think it will last? _____

_____

What type of treatment do you wish to receive? _____

_____

What else do you think will assist to resolve the issue? _____

_____

What is the most important result you hope to receive? _____

_____

What do you most fear most about your illness/injury? _____

_____

# Review of Systems

**Name:**_____ **Date:**_____

**Temperature:**
__Hot __Cold __ Alternating hot and cold __Cold hands and feet __Prefer warmth __Prefer cold

**Thirst:**
__No thirst __Strong thirst __Thirst for cold drinks __Thirst for warm drinks

**Sweat:**
__Night sweats __Profuse sweating __Spontaneous sweating

**Headache:**
__Pressure __Throbbing __Sharp __Dull __Migraine (Where:_____)

**Throat:**
__Dryness __Red __Sore __Irritated __Itchy __Lumps or Masses __Swollen glands _Reflux __Difficulty swallowing __Postnasal drip

**Eyes/Vision:**
__Red __Dry __Sore __Irritated __Itchy __Discharge __Blurry __Floaters __Straining __Poor night vision __Double vision

**Mouth:**
__Sores __Jaw Pain __TMJ __Dry __Dental issues

**Ears:**
__Poor hearing __Pain __Itchy __Wax __Ringing __Discharge

**Nose:**
__Discharge (Color:_____) __Thin __Thick __Watery __Pain __Poor sense of smell __Congestion __Blood

**Lungs:**
__Shortness of breath __Phlegm (Color/ Thickness: _____) __Cough __Wheezing __Snoring __Difficulty breathing __Congestion __Worse during day __Worse at night

**Cardiac:**
__Palpitations __History of heart attack/disease __High cholesterol __High blood pressure __Chest pain __Fast heart rate __Slow heart rate __Pacemaker

**Abdomen:**
__Pain (Where:_____) __Constant __Intermittent __Worse after eating __Bloating __Constipation __Diarrhea __Hemorrhoids/ blood in stool __Black stool __Nausea __Vomiting __Gas __Low appetite __High appetite __Food allergies

**Menstruation and Pregnancies:**
__Painful periods __Heavy flow __Medium flow __Light flow ___No periods __Clots __Pain with intercourse __Pelvic/Vaginal pain __Itching __Sores
Color of menstrual cycle:_____
Color of discharge:_____
Total days of cycle:_____
Total days of bleeding:_____
Pregnancies:_____Live births:_____
Abortions/miscarriages:_____

**Urology:**
__Urgent urination __Painful urination __Copious urination __Small amounts urination __Burning urination __Difficulty urinating __Itchy __Night urination
Color:_____
__Pain in testicles/penis/pelvis __Difficult/ painful/spontaneous ejaculation __Erectile dysfunction __Testicular mass/redness __Irregular ejaculate/discharge

**Limbs:**
__Pain in muscles/joints/tendons __Muscle spasms __Weakness __Decreased range of motion __Edema/water retention

**Spine:**
__Neck pain __Mid-back pain __Low back pain __Tailbone pain __Scoliosis __Arthritis/ degeneration __Bulging disk __Muscle spasm __Decreased range of motion

**Neurological:**
__Difficulty falling asleep __Sleep interrupted __Sleep 8-10 hours __Sleep 6-8 hours __Sleep less than 6 hours __Tremor/convulsions __Numbness/tingling __Balance problems __Vertigo/dizziness __Fainting/loss of consciousness

**Psychological:**
__Anxiety __Depression __Phobias __Memory problems __Attention problems __Addiction __Nightmares __Relationship difficulties

**General:**
__Fatigue __Thyroid problems __Diabetes __Cancer __Frequent colds/infections __Skin rashes/sores __Easy bruising __Change in weight __Hair loss

# Current Medication

Name: _____ Date: _____

Please include all prescriptions, over the counter medications, vitamins, and supplements.

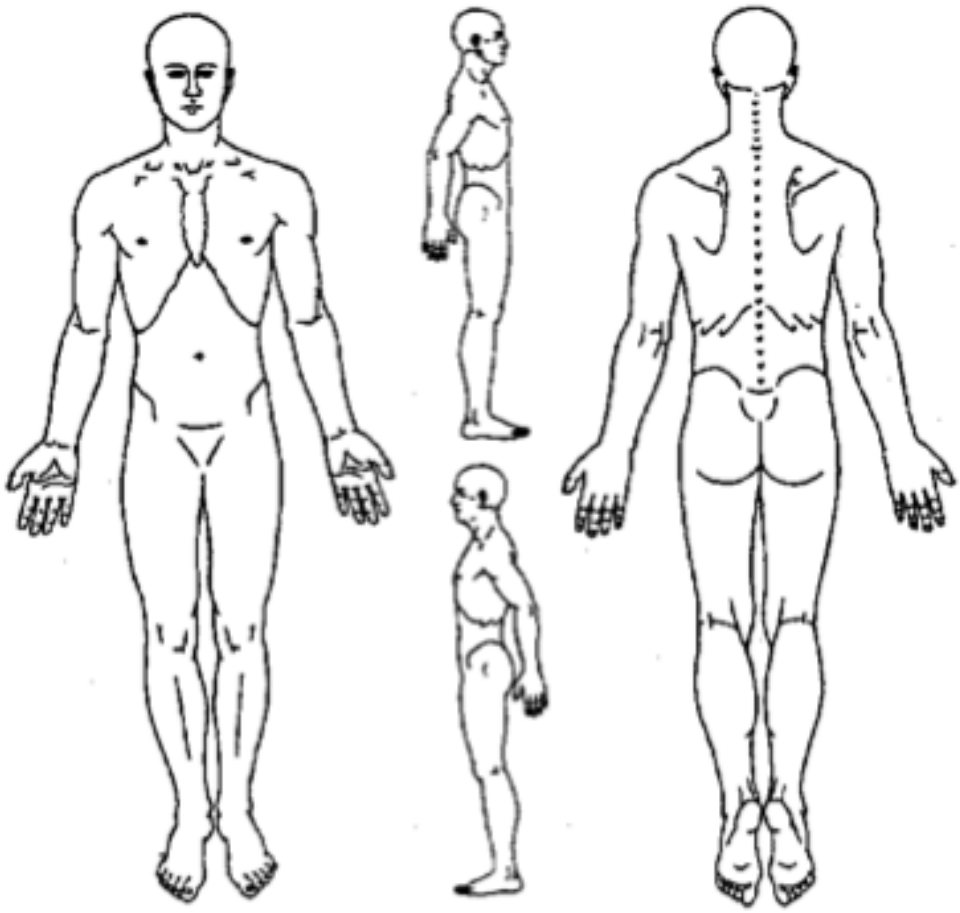
| Medication Name | Dosage |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

# Pain Diagram

Name: _____ Date: _____

Use the diagram and symbols below to indicate any pain or discomfort. Notate the intensity by using One (1) for mild pain to Ten (10) for the worst pain possible.

| Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|
| - - - - - - | o o o o o | ^ ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |
| - - - - - - | o o o o o | ^ ^ ^ ^ ^ | x x x x | ⊗ ⊗ ⊗ ⊗ |



Comments:_____

_____

_____

_____

_____