

FAMILY HISTORY:

PLEASE FILL IN THE AGE AND HEALTH INFORMATION FOR FAMILY MEMBERS. PLACE A CHECKMARK WHERE THEY HAVE A HISTORY THAT IS APPLICABLE.

	FATHER	MOTHER	SIBLINGS	SELF	CHILD	SPOUSE
HEALTH (G-GOOD; P- POOR)						
AGE (IF LIVING)						
IF DECEASED, AGE AT DEATH						
CAUSE OF DEATH						
CANCER/TUMOR						
DIABETES						
HEART DISEASE						
HIGH BLOOD PRESSURE/STROKE						
PNEUMONIA						
EPILEPSY						
MENTAL ILLNESS						
ASTHMA, HAY FEVER, HIVES						
ANEMIA						
KIDNEY DISEASE						
GLAUCOMA						
TUBERCULOSIS						

WEIGHT _____ LB. MAXIMUM WEIGHT _____ LB. WHEN? _____ HEIGHT _____

CHILDHOOD ILLNESSES:

SCARLET FEVER YES NO
 MUMPS YES NO
 CHICKEN POX YES NO
 DIPHTHERIA YES NO
 MEASLES YES NO
 RHEUMATIC FEVER YES NO
 GERMAN MEASLES YES NO

IMMUNIZATIONS:

MEASLES/MUMPS/RUBELLA YES NO
 TETANUS WHEN? _____ YES NO
 PERTUSSIS YES NO
 POLIO YES NO
 DIPHTHERIA YES NO
 OTHER YES NO

ALLERGIES: ARE YOU HYPERSENSITIVE OR ALLERGIC TO:

ANY DRUGS? YES NO PLEASE LIST _____

ANY FOODS? YES NO PLEASE LIST _____

TYPICAL FOOD INTAKE:

BREAKFAST _____

DINNER _____

LUNCH _____

SNACKS- _____

SYMPTOM PROFILE :

FOR THE FOLLOWING, PLEASE CIRCLE **YES** FOR A CONDITION YOU HAVE CURRENTLY AND **PAST** FOR A CONDITION YOU HAD IN THE PAST, NOTING THE DATE IN THE SPACE PROVIDED.

SKIN DISORDERS :

RASH YES PAST _____
 ACNE, BOILS YES PAST _____
 COLOR CHANGE YES PAST _____
 ECZEMA, HIVES YES PAST _____
 PSORIASIS YES PAST _____
 ITCHING YES PAST _____
 ACUTE HAIR LOSS YES PAST _____
 NAIL FUNGUS YES PAST _____
 OTHER _____

RESPIRATORY SYSTEM DISORDERS :

FREQUENT COLDS YES PAST _____
 SINUS CONGESTION YES PAST _____
 NASAL DRAINAGE YES PAST _____
 TO THROAT _____
 CHRONIC COUGH YES PAST _____
 TEMPORARY COUGH YES PAST _____
 SPITTING UP BLOOD YES PAST _____
 ASTHMA (CHRONIC) YES PAST _____
 PNEUMONIA YES PAST _____
 EMPHYSEMA YES PAST _____
 PAIN IN BREATHING YES PAST _____
 TUBERCULOSIS YES PAST _____
 BRONCHITIS YES PAST _____
 PLEURISY YES PAST _____
 SHORTNESS OF YES PAST _____
 BREATH _____
 OTHER _____

SPOTS IN FRONT YES PAST _____
 OF EYES _____
 IMPAIRED VISION YES PAST _____
 COLOR BLINDNESS YES PAST _____
 DOUBLE VISION YES PAST _____
 CATARACTS YES PAST _____
 CONTACTS/GLASSES YES PAST _____
 TEARING OR YES PAST _____
 DRYNESS _____
 GLAUCOMA YES PAST _____
 EYE PAIN/STRAIN YES PAST _____
 IMPAIRED HEARING YES PAST _____
 EARACHES YES PAST _____
 RINGING IN EARS YES PAST _____
 DIZZINESS YES PAST _____
 HAY FEVER YES PAST _____
 NOSE BLEEDS YES PAST _____
 LOSS OF SMELL YES PAST _____
 TEETH GRINDING YES PAST _____
 DENTAL CAVITIES YES PAST _____
 ORAL SORES YES PAST _____
 BLEEDING GUMS YES PAST _____
 DRY MOUTH YES PAST _____
 ORAL THRUSH YES PAST _____
 FREQUENT SORE YES PAST _____
 THROAT _____
 HOARSENESS YES PAST _____
 TROUBLE SWALLOWING YES PAST _____
 SWOLLEN GLANDS YES PAST _____
 OTHER _____

EMOTIONAL/MENTAL ILLNESS :

MOOD SWINGS YES PAST _____
 ANXIETY YES PAST _____
 DEPRESSION YES PAST _____
 CONSIDERED OR YES PAST _____
 ATTEMPTED SUICIDE _____
 IRRITABILITY YES PAST _____
 OTHER _____

DIGESTIVE SYSTEM DISORDERS :

NAUSEA YES PAST _____
 VOMITING YES PAST _____
 LOSS OF APPETITE YES PAST _____
 ULCER YES PAST _____
 HEARTBURN YES PAST _____
 LOOSE STOOL YES PAST _____
 GAS, BLOATING YES PAST _____
 INTERNAL CRAMPING YES PAST _____
 DIARRHEA YES PAST _____
 CONSTIPATION YES PAST _____
 HEMORRHOIDS YES PAST _____
 BLOOD IN STOOL YES PAST _____
 BOWEL MOVEMENTS HOW OFTEN? _____
 IS THIS A CHANGE? _____
 OTHER _____

HEAD, EAR, EYES, NOSE, THROAT :

NECK PAIN/ YES PAST _____
 STIFFNESS _____
 GOITER YES PAST _____
 HEADACHES YES PAST _____
 MIGRAINES YES PAST _____
 HEAD INJURY YES PAST _____
 JAW, TMJ YES PAST _____

CARDIOVASCULAR DISORDERS :

HIGH/LOW BLOOD PRESSURE YES PAST _____
 HEART DISEASE YES PAST _____
 CHEST PAIN YES PAST _____
 HEART MURMUR YES PAST _____
 FAINTING YES PAST _____
 PALPITATIONS/FLUTTERING YES PAST _____
 PHLEBITIS YES PAST _____
 BLOOD CLOTS YES PAST _____
 SWELLING ANKLES YES PAST _____
 ENDOCARDITIS YES PAST _____
 OTHER _____

URINARY TRACT DISORDERS :

FREQUENT INFECTION YES PAST _____
 FREQUENT NIGHT URINATION YES PAST _____
 INABILITY TO HOLD URINE YES PAST _____
 BURNING/PAIN ON URINATION YES PAST _____
 INCREASED FREQUENCY YES PAST _____
 KIDNEY STONES YES PAST _____
 OTHER _____

MUSCULASKELATAL DISORDERS :

WEAKNESS YES PAST _____
 MUSCLE SPASMS/CRAMPS YES PAST _____
 JOINT PAIN/STIFFNESS YES PAST _____
 ARTHRITIS YES PAST _____
 SCIATICA YES PAST _____
 FIBROMYALGIA YES PAST _____
 BROKEN BONES YES PAST _____
 PAIN, WHERE? YES PAST _____
 OTHER _____

MISCELLANEOUS :

EASY BLEEDING/BRUISING YES PAST _____
 VARICOSE VEINS YES PAST _____
 ANEMIA YES PAST _____
 SLOW WOUND HEALING YES PAST _____
 CHRONIC INFECTIONS YES PAST _____
 NIGHT SWEATS YES PAST _____
 DAY SWEATS YES PAST _____
 COLD HANDS/FEET YES PAST _____
 HEAT OR COLD YES PAST _____

INTOLERANCE
 FATIGUE YES PAST _____
 CHRONIC FATIGUE SYNDROME YES PAST _____
 HYPOGLYCEMIA YES PAST _____
 HYPOTHYROID YES PAST _____
 HYPERTHYROID YES PAST _____
 EXCESSIVE THIRST YES PAST _____
 EXCESSIVE HUNGER YES PAST _____
 DIABETES YES PAST _____
 GALLBLADDER DISEASE YES PAST _____
 LIVER DISEASE YES PAST _____
 HEPATITIS TYPE? YES PAST _____
 JAUNDICE YES PAST _____
 OTHER _____

HABITS :

DO YOU EXERCISE YES NO
 WHAT KIND _____
 HOW OFTEN _____
 EAT 3 MEALS A DAY YES NO
 BEEN TREATED FOR DRUG DEPENDENCE YES NO
 SLEEP WELL YES NO
 TAKE VACATIONS YES NO
 AVERAGE 6-8 HOURS SLEEP YES NO
 EAT OUT OFTEN YES NO
 AWAKEN RESTED YES NO
 GO ON DIETS OFTEN YES NO
 SPEND TIME OUTSIDE YES NO
 DRINK ALCOHOL YES NO
 HOW MUCH _____
 DRINK CAFFEINATED BEVERAGES YES NO
 HOW OFTEN _____
 USE TOBACCO YES NO
 HOW MUCH _____
 SMOKED PREVIOUSLY YES NO
 HOW LONG? _____ PACKS/DAY _____
 HISTORY OF ABUSE PSYCHOLOGICAL, PHSYICAL, SEXUAL YES NO
 WHAT TIME OF DAY IS YOUR ENERGY AT IT'S BEST? _____

FOR MEN :

TESTICULAR MASSES YES NO
 IMPOTENCE YES NO
 PROSTATE DISEASE YES NO
 PREMATURE EJACULATION YES NO
 DISCHARGE OR SOARS YES NO

TESTICULAR PAIN	YES	NO
CHLAMYDIA	YES	NO
HERNIAS	YES	NO
CONDYLOMA	YES	NO
FOR MEN CONTINUED :		
GENITAL, ORAL, OR	YES	NO
RECTAL HERPES		
SYPHILIS	YES	NO
OTHER _____		

FOR WOMEN ONLY :

BREAST PAIN/ TENDERNESS	YES	NO
BREAST LUMPS	YES	NO
NIPPLE DISCHARGE	YES	NO
VAGINAL DISCHARGE	YES	NO
ABNORMAL PAP SMEAR	YES	NO
CERVICAL DYSPLASIA	YES	NO
GONORRHEA	YES	NO
SYPHILIS	YES	NO
GENITAL, ORAL, OR	YES	NO
RECTAL HERPES		
CLOTTING DURING MENSES	YES	NO
IRREGULAR MENSES	YES	NO
PMS SYMPTOMS	YES	NO
OTHER _____		

AGE AT FIRST MENSES _____

LENGTH OF CYCLE IN DAYS _____

DURATION OF CYCLE IN DAYS _____

SEXUALLY ACTIVE	YES	NO
BIRTH CONTROL	YES	NO
NUMBER OF PREGNANCIES	_____	
NUMBER OF LIVE BIRTHS	_____	
NUMBER OF MISCARRIAGES	_____	
NUMBER OF ABORTIONS	_____	
FIBROIDS	YES	NO
CONDYLOMA	YES	NO
ENDOMETRIOSIS	YES	NO
OVARIAN CYSTS	YES	NO
SEXUAL DIFFICULTIES	YES	NO
MENOPAUSAL SYMPTOMS	YES	NO
PAINFUL MENSES	YES	NO
BLEEDING BETWEEN CYCLES	YES	NO