

Health History

This information is confidential and will only be released with your signed consent.

Full Name: _____ Today's Date: _____

Address: _____ Email: _____

Phone: (W) _____ (H) _____ (C) _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

If under 18, parents name/address: _____

Birthdate: _____ Age: ____ Sex: ____ Height: _____ Weight: _____ Occupation: _____

Marital Status: _____ Living Situation: _____

Education (highest completion): Elementary HS College Grad school Vocational Prof Post-Grad

How did you hear about my homeopathic practice?: _____

Primary Physician: _____ Other Physician: _____

Current Alternative Health Care Practitioners: _____

Family Health History

Check here if family history is unknown

	Age	If dead, cause of death
Father		
Mother		
Siblings		

Children	Age	Problems

Check the following items that apply to blood relatives (children, sisters, brothers, parents, grandparents, aunts, uncles).

- | Yes | Relationship |
|--------------------------|----------------------------|
| <input type="checkbox"/> | Alcohol/drug problem _____ |
| <input type="checkbox"/> | Allergy/asthma _____ |
| <input type="checkbox"/> | Anemia _____ |
| <input type="checkbox"/> | Arteriosclerosis _____ |
| <input type="checkbox"/> | Arthritis _____ |
| <input type="checkbox"/> | Binge eating/bulimia _____ |
| <input type="checkbox"/> | Cancer _____ |
| <input type="checkbox"/> | Diabetes _____ |
| <input type="checkbox"/> | Epilepsy/seizures _____ |
| <input type="checkbox"/> | Gonorrhea _____ |
| <input type="checkbox"/> | Heart disease _____ |
| <input type="checkbox"/> | Other not mentioned _____ |

- | Yes | Relationship |
|--------------------------|----------------------------|
| <input type="checkbox"/> | High blood pressure _____ |
| <input type="checkbox"/> | High cholesterol/fat _____ |
| <input type="checkbox"/> | Kidney disease _____ |
| <input type="checkbox"/> | Liver disease _____ |
| <input type="checkbox"/> | Mental illness _____ |
| <input type="checkbox"/> | Obesity _____ |
| <input type="checkbox"/> | Skin disease _____ |
| <input type="checkbox"/> | Suicide _____ |
| <input type="checkbox"/> | Syphilis _____ |
| <input type="checkbox"/> | Thyroid disease _____ |
| <input type="checkbox"/> | Tuberculosis _____ |
| <input type="checkbox"/> | Ulcers _____ |

Past History of Illness and Medical Problems

Surgery: List all surgery	When	Other hospitalizations	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Broken bones and/or traumatic injuries include all car accidents or concussions

Dates

Major complaints and duration

Duration

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past History

Yes	When	Yes	When	Yes	When
<input type="checkbox"/> Acne	_____	<input type="checkbox"/> Fibroids	_____	<input type="checkbox"/> Periodontal disease	_____
<input type="checkbox"/> AIDS/HIV	_____	<input type="checkbox"/> Gallbladder problems	_____	<input type="checkbox"/> Phlebitis	_____
<input type="checkbox"/> Alcohol/Drug problem	_____	<input type="checkbox"/> Glasses/contacts	_____	<input type="checkbox"/> Pneumonia	_____
<input type="checkbox"/> Allergies	_____	<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Premenstrual tension	_____
<input type="checkbox"/> Amalgams/silver fillings	_____	<input type="checkbox"/> Gonorrhea	_____	<input type="checkbox"/> Prostate problems	_____
<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Psychotherapy	_____
<input type="checkbox"/> Antibiotics more than once a year	_____	<input type="checkbox"/> Hay Fever	_____	<input type="checkbox"/> Reactions to vaccinations	_____
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> Hearing Problem	_____	<input type="checkbox"/> Rheumatic fever	_____
<input type="checkbox"/> Arteriosclerosis	_____	<input type="checkbox"/> Heart attack	_____	<input type="checkbox"/> Root canals	_____
<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Heart failure	_____	<input type="checkbox"/> Scarlet fever	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Heart problem	_____	<input type="checkbox"/> Sexually transmitted disease	_____
<input type="checkbox"/> Back pain/strain	_____	<input type="checkbox"/> Hemorrhoids	_____	<input type="checkbox"/> Sinusitis	_____
<input type="checkbox"/> Binge eating	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Skin problem	_____
<input type="checkbox"/> Bladder infection	_____	<input type="checkbox"/> Herpes	_____	<input type="checkbox"/> Sleep disorder	_____
<input type="checkbox"/> Blood clots	_____	<input type="checkbox"/> Hiatal Hernia	_____	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Breast fed	_____	<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Suicide attempt	_____
<input type="checkbox"/> Breast lump	_____	<input type="checkbox"/> High cholesterol/triglycerides	_____	<input type="checkbox"/> Syphilis	_____
<input type="checkbox"/> Bronchitis	_____	<input type="checkbox"/> Histoplasmosis	_____	<input type="checkbox"/> Taken steroid (cortisone/prednisone)	_____
<input type="checkbox"/> Bulimia (self-induced vomiting)	_____	<input type="checkbox"/> Hives	_____	<input type="checkbox"/> Thyroid problem	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Hypoglycemia	_____	<input type="checkbox"/> Tonsillitis	_____
<input type="checkbox"/> Cataract	_____	<input type="checkbox"/> Infectious Mononucleosis	_____	<input type="checkbox"/> Tooth problems	_____
<input type="checkbox"/> Chemical sensitivity	_____	<input type="checkbox"/> Insomnia	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/> Kidney infection	_____	<input type="checkbox"/> Urine problems	_____
<input type="checkbox"/> Chronic fatigue	_____	<input type="checkbox"/> Kidney stones	_____	<input type="checkbox"/> Vaginitis	_____
<input type="checkbox"/> Coccidiomycosis	_____	<input type="checkbox"/> Kidney problems	_____	<input type="checkbox"/> Vision problems	_____
<input type="checkbox"/> Colds, frequent	_____	<input type="checkbox"/> Liver disease	_____	<input type="checkbox"/> Warts	_____
<input type="checkbox"/> Colitis	_____	<input type="checkbox"/> Measles	_____	<input type="checkbox"/> Other problems	_____
<input type="checkbox"/> Congenital defect	_____	<input type="checkbox"/> Menstrual problems	_____	<input type="checkbox"/>	_____
<input type="checkbox"/> Counseling	_____	<input type="checkbox"/> Mental Illness	_____	<input type="checkbox"/>	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Migraine	_____	<input type="checkbox"/>	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Mumps	_____		
<input type="checkbox"/> Ear Infection	_____	<input type="checkbox"/> Nervous condition	_____		
<input type="checkbox"/> Eczema	_____	<input type="checkbox"/> Neurological problems	_____		
<input type="checkbox"/> Endometriosis	_____	<input type="checkbox"/> Nightmares—frequent	_____		
<input type="checkbox"/> Epilepsy	_____	<input type="checkbox"/> Overweight >20lbs	_____		
<input type="checkbox"/> Epstein Barr	_____	<input type="checkbox"/> Pelvic infection	_____		
<input type="checkbox"/> Fibrocystic Breasts	_____	<input type="checkbox"/> Peptic ulcer	_____		

Personal History

Current Medications (prescription and non prescription)

Vitamin & Mineral supplements (type & Dosage)

Allergies:

I am allergic to the following medications:

I am allergic to the following foods, chemicals or inhalants:
(Use an additional sheet of paper if necessary)

Lifestyle:

List your favorite foods or cravings:

I usually eat:

- white bread commercial wheat bread whole grain bread

I usually eat:

- fresh frozen canned vegetables

I usually eat my vegetables:

- raw steamed boiled sautéed

I usually eat:

- fresh frozen canned fruits

I eat beef or pork:

- at least once a day five times a week less than three times a week never

I usually prepare my meat and fish:

- pan fried deep fried baked broiled grilled

I eat refined sugar: yes no

My salt use is:

- none added light moderate heavy

I drink water:

- city well spring distilled filtered
_____ glasses a day.

I often eat seconds: yes no

To control my weight, I have used:

- fasting longer than 1 day diet pills laxatives self-induced vomiting enemas diuretics health/diet exercise other _____

I am now or have been a smoker: yes no

How many years have you smoked? _____

When did you quit? _____

What do you smoke now? _____

How much? _____

I estimate my use of:

coffee: ___ cups/day decaf: ___ cups/day

tea: ___ cups/day soda: ___ cans/day

I use beer wine "hard" liquor

I consider myself a:

- non-drinker social drinker heavy drinker alcoholic
 recovering alcoholic

I use: marijuana other drugs: _____

I think I need counseling or medical care to help me control use of:

- alcohol tobacco food drugs.

I have participated in an exercise program: yes no

I exercise on a regular basis: yes no

I think I get enough exercise: yes no

I would like to do more exercise: yes no

I find my work:

- too demanding boring satisfactory very satisfying

My sex life is satisfactory: yes no

I do the following for relaxation/recreation:

Activity	Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I sleep well: yes no

I worry about: money job family life relationships
 other _____

I currently see a psychotherapist or other mental health professional:
 yes no

I have had a therapeutic massage: yes no

I currently see a chiropractor, osteopath, rolfar, massage therapist or other body work professional. yes no

I have been arrested: yes no

I have been in the military yes no

I have been a victim of abuse: physical emotional sexual

My spiritual life is satisfactory: yes no

I am currently involved in a regular spiritual program yes no

My last physical exam was _____

How do you feel when you wake up in the morning?

How often to you ordinarily eat (anything) during a 24 hour period?

Please add anything that you would like to tell us that has not already been covered.

Life Changes

In the last 12 months, what changes have occurred in your life?

Personal Life:

Family Life:

Social Life:

Work Life:

Sex Life:

Any other significant changes:

Review of Systems

Answer "yes" if you have had these symptoms in the past **12 months**.

Yes

- Chronic fatigue
- Mood swings
- Chronic depression
- Trembling episodes
- Light-headedness
- Food cravings
- Frequent infections
- Night Sweats
- Swollen glands
- Skin rash
- Chills/fever
- Change in skin/nails
- Change in wart or mole
- Abnormal bleeding/bruising
- Unusual hair loss/growth
- Change in hair loss/growth
- Irritability
- Restlessness
- Headaches
- Dizziness
- Balance problems
- Head injury
- Seizure/convulsions
- Poor memory
- Difficulty concentrating
- Fainting
- Weakness
- Numbness/tingling
- Blurred vision
- Double vision
- Loss of any vision
- Halos around lights
- Excessive tearing/itching
- Eye pain
- Dark circles under the eyes
- Date last eye exam
- Loss of hearing
- Ringing/buzzing in ears
- Sinus trouble
- Nosebleed
- Sore throat
- Hoarseness
- Change in voice
- Dental problem
- Dry mouth
- Excessive salivation
- Bleeding gums
- Mouth breathing
- Chronic cough
- Bloody/yellow sputum

Yes

- Shortness of breath
 - with exertion
 - at night
- Bronchitis
- Chest pain with breathing
- High blood pressure
- Chest pain or pressure
 - at rest
 - with exertion
 - with stress
 - with eating
 - down left arm, neck or back
 - accompanied by nausea, sweating, anxiety
- Irregular heartbeat
- Skipped heartbeats
- Palpitations
- Fast heart beat
- Heart murmur
- Swelling feet/legs
- Cold hands/feet
- Leg cramps at night
- Pain or fatigue in legs with exercise
- Burning feet
- Sore legs/feet
- Color change legs/arms
- Difficulty swallowing
- Pain/discomfort when eating
- Bad teeth
- Belching
- Coating on tongue
- Pain relieved by eating
- Nausea/vomiting
- Trouble with fried foods
- Bloating of abdomen
- Bowel gas
- Diarrhea
- Constipation
- Black stool
- Clay-colored stool
- Mucus in stool
- Hemorrhoids
- Rectal bleeding
- Abdominal pain
- Change in diet
- Pain/burning during urination
- Frequent urination
- Urination at night
- Blood in urine
- Loss of control/urine

Yes

- Foul odor to urine
- Low back pain
- Muscle pain
 - Where:
- Muscle weakness
 - Where:
- Joint pain
 - Where:
- Joint pain aggravated by motion
- Joint pain relieved by motion
- Swollen joints
- Stiff joints

MEN

- Enlarged prostate
- Decreased urine stream
- Unable to interrupt urine stream
- Dribbling after urination
- Pus or drainage from penis
- Genital swelling/rash
- Problem with sexual function

WOMEN

- Last menstrual period
- Age began menstruation
- Age at menopause
- # of pregnancies
- # of live births
- # of abortions/miscarriages
- Usual length of cycle days
- Usual length of period days
- Date of last Pap smear
- Complication of pregnancy
- Used birth control pills
- Used IUD
- Change in cycle
- Spotting between periods
- Discomfort with periods
- Premenstrual tension
- Vaginal discharge
- Painful intercourse
- Itching
- Self breast examination
- Problem with sexual function
- Lump in breast
- Abnormal pap smear
- Infertility
- Breast fed a baby