HEALTH HISTORY

**CONFIDENTIAL**

NAME (Last, First, MI): Date:

**PLEASE CHECK ANY SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE LAST YEAR**

***GENERAL*** ***RESPIRATORY*** ***DIET/LIFESTYLE*** ***SKIN*** ***MEN ONLY***

 cold hands/feet asthma vegetarian broken blood vessels genital pain

 low energy persistent cough healthy diet blood not clotting impotence

 dizziness coughing blood eat fried foods bruise easily genital sores

 allergies shortness of breath eat a lot of meat discoloration lump in testicles

 fatigue recurrent bronchitis smoke darkness around eyes discharge from penis

 hot flashes phlegm production drink alcohol bags under eyes nocturnal emission

 insomnia difficulty inhaling drink coffee swollen lymph nodes low sexual energy

 spontaneous sweating difficulty exhaling eat a lot of sweets dry skin

 night sweating exercise regularly acne ***WOMEN ONLY***

 lack of sweating ***CARDIOVASCULAR*** exercise excessively brittle nails abnormal pap smear

 recent weight loss chest pain lack of exercise premature gray hair bleeding between periods

 recent weight gain high blood pressure dry, brittle hair irregular periods

 aversion to heat low blood pressure ***GENITOURINARY*** hair loss heavy periods

 aversion to cold irregular heart beat up at night to urinate painful periods

 weak immune system poor circulation dark urine **NEUROLOGICAL**  premenstrual tension

 swelling of ankles blood in urine fainting breast lumps

***NECK AND HEAD***  varicose veins cloudy urine convulsions low sexual energy

 blurred vision rib/side pain burning urination handwriting change vaginal discharges

 floaters scanty urine paralysis menopausal

 heaviness in the head ***GASTROINTESTINAL*** profuse urine stroke uterine prolapse

 headache abdominal pain frequent urination seizures facial hair

 phlegm in throat bloating poor bladder control tremor may be pregnant

 cataracts belching urgency to urinate clumsiness pain with intercourse

 double vision gas prolapsed bladder drowsiness

 earache constipation vertigo

 ear discharge diarrhea/loose stools ***MUSCULOSKELETAL***

 eye pain/strain bloody stools pain, weakness, ***EMOTIONAL***

 corrected vision black stools numbness in: nervousness

 nasal obstruction difficulty swallowing arms irritability

 nasal discharge poor appetite legs anger

 loss of sense of smell heartburn/acid reflux hands troubling dreams

 hearing loss hemorrhoids feet weepy

 hoarseness indigestion joints depression

 nosebleeds stomach ache shoulders forgetfulness

 recurrent sore throat nausea hips mind not clear

 red/inflamed eyes vomiting neck anxiety

 ringing in ears food sensitivities elbows fear

 sinus problems knees unrestrained joy

MEDICAL HISTORY

**CONFIDENTIAL**

NAME (Last, First, MI): Date:

MAJOR COMPLAINT(S) OR HEALTH CONDITIONS:

HAVE YOU EVER RECEIVED TREATMENT FOR THIS CONDITION? IF SO, WHEN?

WHAT WAS THE DIAGNOSIS?

WHAT DIDTHE TREATMENT CONSIST OF?

DOES ANYTHING MAKE IT BETTER? WORSE?

WHAT WERE THE RESULTS OF THE TREATMENT?

List any substances you are allergic to:

List medication, vitamins, or herbal/nutritional supplements you are currently taking or have taken in the last 2 months:

List any major surgeries you have had:

SIGNIFICANT TRAUMA (Auto accidents, falls, etc.)

SIGNIFICANT ILLNESSES (Please check all that apply)

 ARTHRITIS DIABETES HEART DISEASE THYROID DISEASE

 ASTHMA ENDOMETRIOSIS HYPERTENSION VENEREAL DISEASE

 AUTOIMMUNE DISEASE FIBROMYALGIA KIDNEY STONES OTHER

 AIDS GALLSTONES RHEUMATIC FEVER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CANCER GERD SCOLIOSIS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CHRONIC PAIN HEPATITIS SEIZURES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_