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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_