Patient Medical History

Name _______________________________ Age_____ Sex____ Height____ Weight________

Present complaint:
____
____

First noticed?____________________________________

Occupation:____________________________________

No. of children__________

Religion (optional):___________________________

Have you been exposed to toxic chemicals?______

If yes, which ones?___________________________
____
____

Other health care providers you are seeing, and their specialties:
____
____
____
____
____
____

What diagnosis(s) were you given?____________
____
____
____

Women only (next two lines):

Age at onset of menstruation:________________

No. of miscarriages/c-sections:_______________

Number of children:__________________________

Age at onset of menopause:__________________

How was your health as a child? (circle one): excellent good fair poor

Were there any complications with your delivery? Please explain:__________________________________

Were you breast fed?__________ How long?____

Did you have any serious emotional or mental traumas as a child? Please explain:___________________

Check diseases for which you have been immunized:

☐ measles ☐ mumps ☐ rubella ☐ small pox ☐ influenza ☐ tetanus ☐ diphtheria ☐ other__________

What is your blood type? (circle one): **A** **B** **AB** **O** **don't know**

Serious Illnesses / Injuries / Surgeries	Date	Outcome

	Allergies / Sensitivities (Please Specify)	Typical Reaction
	Animal hair/dander:	
	Chemicals:	
	Drugs, medications:	
	Dust, molds:	
	Food:	
	Grasses, weeds, pollen:	
	Others:	

Tests History

Please list the date of your most recent procedures. Circle any tests that were abnormal:

Test	Year	Test	Year	Test	Year	Test	Year
☐ Chest x-ray		☐ TB Test		☐ Pap Smear		☐ Others:	
☐ Kidney x-ray		☐ EKG		☐ Mammogram			
☐ G.I. Series		☐ MRI		☐ Sigmoidoscopy			
☐ Colon x-ray		☐ CAT Scan		☐ Rectal Exam			
☐ Spine x-ray		☐ Cardiac Stress Test		☐ PSA			
☐ Blood Tests		☐ Cholesterol		☐ Complete Physical Exam			

Health Habits (Please print clearly)

Please list all supplements / herbs / homeopathics you are currently taking (attach a separate sheet if necessary):

Type (include brand name)	**Dosage**

Please circle any of the following medications you are currently taking or have taken within last 3 months:

Allergy medication	Chemotherapy	Oral Contraceptives	Ulcer Medication
Antacids	Cortisone	Pain Medication	Other________________
Anti-inflammatory	Heart Medications	Radiation	____________________
Antibiotic /Anti-fungal	High Blood Pressure	"Recreational" Drugs	____________________
Antidepressants	Hormones	Relaxants	____________________
Aspirin/Tylenol / Advil	Lithium	Thyroid	

Do you:
(Circle day or week, as appropriate):

☐ Use tobacco ______packs per day/week How Many Years?_________
☐ Drink coffee ______cups per day/week
☐ Drink black tea ______cups per day/week
☐ Drink alcohol ______cups per day/week
☐ Drink sodas ______cups per day/week
☐ Use artificial sweeteners ______packets per day/week
☐ Use margarine ______pats per day/week

How many times a week do you eat in a restaurant? Breakfast_______ Lunch_______ Dinner_________

What types of restaurants?____

What are your favorite foods: sushi animal protein ____

Do you crave sweets?_____ At what time?:___________ Do you salt your food at the table?_________

Are there other foods you crave? (Please Circle) Bread Pasta Dairy Meat Other: _____________

What foods do you really dislike: ____

Are you on any specific diet? If so, please specify: ____

Would you like to increase or decrease your weight? If so, by how much: ________________________

When did you last have a significant (more than 10 pounds) change in weight?_____________________

What exercise do you do and how often? ____

How many hours of sleep do you get each night? _______ Do you wake rested?___________________

Are you presently sexually active? _______ Any difficulties? _______ Method of B.C.?_______________

Rate your current stress level from 1-10: _________ How much does this affect you (1-10)? __________

What are the major stress factors in your life now? ____

Rate your current emotional health (circle): excellent good fair poor unstable crisis

Are you currently in psychotherapy?_________ Do you have a good support network/team? _________

Does your home environment have a supportive effect on your health? dorm ______________________

How many hours of relaxation (not including sleep) do you give yourself during the work week?________

During weekends? _______ Favorite recreational activities? ________________________________

When was your last eye exam?___________ Do you wear contacts?_______ Hard or soft? glasses ___

Do you drink purified or bottled water? ______If so, what brand do you use?_______________________

Do you have an air purifier in the room you sleep in?______ What brand?________________________

Do you have amalgam (silver) fillings?______ Any other dental problems?________________________

Do you make an effort to eat organically grown foods?______ What % of your diet?________________

Are you on a restricted diet? Please explain:____

Are you considering any elective surgery or medical procedures in the near future? ________________

Family Health History

Relation	Age	State Of Health (if living)	Age At Death	Cause of Death	Check (x) if your blood relatives have/had:		
						Disease	Relationship
Father						Arthritis, gout	
Mother						Asthma, hay fever	
Brothers						Cancer	
						Chemical dependency	
						Diabetes	
						Heart disease, stroke	
Sisters						High blood pressure	
						Syphilis, gonorrhea	
						Tuberculosis	
						Other	

Diet Survey

Please list everything you eat and drink for 2-3 days:

Time	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						