Patient Name:_____ Date_____

Medical History Form

This is my complete medical, nutritional and social history. As a consultant you may not require all of this information for your evaluation/treatment, but I provide it to save time in the consultation for discussion and questions. Please make this a part of my medical record in your chart, and the same restrictions apply to this document as to any other document in my chart, in that I do not wish this to be duplicated and sent to any person, company or organization without my knowledge and specific consent.

First Name_____M.I.____Last Name_____ Gender: M( ) F( )

Date of birth:____/____/_____ Age_____ SSN:_____

Home address:_____

_____Birth Country_____

Occupation:_____Company:_____

Health Insurance:_____Member ID:_____

Group #_____ Address:_____

Name of Insured Self ( ) Spouse ( )_____

Referred by:_____ Height_____ Weight_____

Ethnic/racial origin: ( )African American ( ) Hispanic ( ) Mediterranean

( ) Native American ( ) Northern European ( ) Asian ( ) Jewish

Current Problems	**Onset**	**Treatment tried**	**Success**

1._____

2._____

3._____

4._____

5._____

Patient Name:_____ Date_____

Additional Details about current problems:_____

Past Medical/Surgical History:

ILLNESSES	WHEN	COMMENTS
Anemia		
Arthritis		
Asthma		
Bladder control problems		
Bronchitis		
Pneumonia		
Cancer		
Constipation		
Chronic Fatigue		
Concentration/focus problem		
Crohn's Disease/Ulc. Colitis		
Diabetes		
Disc Disease		
Diarrhea		
Endometriosis		
Emphysema		
Epilepsy (seizures)		
Epstein-Barr virus infection		
Fatigue		
Fever		
Gallstones/ Gall bladder dis.		
Gout		
Irregular periods		
Heart Attack/ Angina		
Heart failure		
Hepatitis		
High Cholesterol		
High blood pressure		
Irritable bowel		
Insomnia		
Kidney stones		
Memory impairment		
Mononucleosis		
Ovarian cyst		
Overweight		
Pain		

Patient Name:_____ Date_____

ILLNESSES (CONT)	WHEN	COMMENTS
Parasite infection		
Polycystic ovarian syndrome		
Pneumonia		
Rheumatic fever		
Rheumatoid arthritis		
Sinusitis		
Sleep apnea		
Sleep disturbance		
Stroke		
Thyroid problems		
Urinary tract infections		
Vaginitis		
Vaginal pain		
Weakness		
Weight loss		
Weight gain		
Yeast (Candida) Infections		

INJURIES	WHEN	COMMENTS
Back Injury		
Knee Injury		
Head Injury		
Fracture: Describe:		

SURGERIES	WHEN	COMMENTS
Appendectomy		
Dental surgery		
Gall bladder		
Hernia		
Hysterectomy		
Tonsillectomy		

Patient Name:_____ Date_____

HOSPITALIZATIONS (WHERE)	WHEN	REASON (OUTCOME)

MEDICATIONS	STARTED/STOPPED	DOSAGE	BENEFIT?

Antibiotic Use: < 5 times > 5 times

Infancy/Childhood _____ _____

Teen Years _____ _____

Adulthood _____ _____

Patient Name:_____ Date_____

Steroid (cortisone/prednisone) Use < 5 times >5 times

Infancy/Childhood _____ _____

Teen Years _____ _____

Adulthood _____ _____

NUTRITIONAL SUPPLEMENTS	STARTED	DOSAGE
Multivitamin		
Omega-3 (Fish oil/Flax seed)		
Calcium/Mg Supplement		
Vitamin C		
Vitamin E		
Vitamin D		
B Vitamins		

Patient Name:_____ Date_____

TOXIN EXPOSURE

Alcohol use ( ) Never ( ) 1-3 drinks per week ( ) 1-2 drinks per day ( ) > 2 drinks/day
I do ( ) do not ( ) think that I have a problem with alcohol consumption

Cigarette Smoking: ( ) Never ( ) Used to, but quit _____years ago
Years smoking _____ Pack(s)/day _____

Exposure to second hand smoke: ( ) Yes, when I was a child
( ) Yes, currently
( ) Never/rarely

Recreational Drug Use: ( ) Yes, but several years ago
( ) Yes, currently _____
( ) No, never

I have mercury/amalgam fillings: ( ) Yes, but had them all removed
( ) Yes, and still have them
( ) No, never

Industrial chemical exposure ( ) Yes, at my place of employment
( ) Yes, near where I live
( ) Only in the past
( ) No, never

I have been exposed to the following toxic metals at my job/ at home:
( )Lead ( )Mercury ( )Cadmium ( )Arsenic ( ) Cadmium ( ) Aluminum

Artificial Joints/ Implants: ( ) Knee ( ) Hip ( ) Breast ( ) Facial ( ) Other

Other toxin exposure (explain)_____

_____

I am bothered by odors/fumes ( ) Very sensitive ( ) Somewhat sensitive ( ) Not bothered

EXERCISE/ACTIVITY

I exercise _____times per week, and the exercise lasts _____minutes each time.

Types of exercise: (hours/week)

_____jogging/walking _____tennis _____golf _____dancing _____bowling

Patient Name:_____ Date_____

_____raquetball/squash _____basketball _____yoga _____gardening _____swimming

_____aerobics _____weight lifting _____pilates/gyrotonics _____tai chi/ chi gong,

_____other_____

SYMPTOM CHECKLIST **COMMENTS:**

CENTRAL NERVOUS SYSTEM	**MILD**	**MOD**	**SEVERE**
Vision problems			
Headache			
Migraines			
Tremor			
Loss of consciousness			
Balance problems			
Twitching muscles			
Restless legs			
Sleepwalking			
Seizures			
Dizziness			
Hallucinations			
Anxiety			
Difficulty with:			
Speech			
Memory			
Concentration			
Balance			
Hearing			
Irritability			
Rage			
Blackouts			
Depression			
Mania			
HEAD/EYES/ EARS	**Mild**	**Mod**	**Severe**
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear sounds (tinnitus)			

Patient Name:_____ Date_____

Ear pain			
Sensitive to sounds			
HEENT:	**Mild**	**Mod.**	**Severe**
Migraine			
Double vision			
Blurry vision			
MUSCLE/BONE	**Mild**	**Mod**	**Severe**
Muscle spasm			
Back pain			
Calf cramping			
Chest tightness			
Foot cramps			
Joint pain			
Joint swelling			
Numbness			
Tingling			
Shooting pains			
Muscle pain			
Weakness			
Tendonitis			
Numbness:			
Hands			
Feet			
Other:			
GENERAL;	**Mild**	**Mod**	**severe**
Fatigue			
Cold hands & feet			
Cold intolerance			
Fever			

Patient Name:_____ Date_____

Flushing			
Heat intolerance			
Food cravings			
Binge eating			
Night eating			
Tired after eating			
Nausea/vomiting			
Nightmares/vivid dreams			
Sleep terror			
RESPIRATORY	**Mild**	**Mod**	**Severe**
Foul breath			
Shortness of breath			
Coughing			
Wheezing			
Hoarse voice			
Congestion			
Sinus drainage			
Sinus pain			
Snoring			
Hay Fever			
CARDIOVASCULAR	**Mild**	**Mod**	**Severe**
Chest pain			
Angina			
Heart Attack			
Heart murmur			
High blood pressure			
Fast heart rate			
Irregular pulse			
Valve prolapse			

Patient Name:_____ Date_____

Bypass surgery			
Stent			
Phlebitis			
Edema			
Varicose veins			
Slow pulse			
URINARY	**Mild**	**Mod**	**Severe**
Bet wetting			
Diff. starting urine			
Bladder infection			
URINARY (CONT)	**Mild**	**Mod**	**Severe**
Kidney stone			
Kidney disease			
Painful urination			
Urine leaking {incontinence)			
Prostate enlargement			
Prostate infection			
Bladder pain/pressure			
FEMALE OB/GYN	**Mild**	**Mod**	**Severe**
Cystic breasts			
Lumps in breast			
Fibroids			
Abnormal bleeding			
Low libido			
Endometriosis			
Vaginal discharge			
Vaginal itching			
Vaginal pain			
Infertility			

Patient Name:_____ Date_____

Premenstrual	**mild**	**mod**	**severe**
Bloating			
Breast tenderness			
Carbs craving			
Chocolate craving			
Constipation			
Decreased sleep			
Irritability			
Diarrhea			
Edema			
Fatigue			
Bladder control prob.			
Bladder pain			
Low libido			
Menstrual	**Mild**	**Mod**	**Severe**
Cramps			
Heavy periods			
Passing clots			
Missed periods			
Scanty periods			
Spotting between periods			
GASTROINTESTINAL	**Mild**	**Mod**	**Severe**
Anal spasm			
Hemorrhoids			
Tooth decay			
Bad breath			
Bleeding gums			
Difficulty swallowing			
Bloated stomach			

Patient Name:_____ Date_____

Bloated abdomen (lower)			
Blood in stool			
Belching			
Canker sores			
Acid indigestion			
Vomiting/nausea			
Diarrhea			
Constipation			
Pain with fatty foods			
Dry mouth			
Farting			
Abdominal pain			
Light colored stools			
Black stools			
Blood mixed in stool			
Food Intolerance to:	**Mild**	**Mod**	**Severe**
Dairy products			
Grains/gluten			
Soy/ peanuts/ nuts			
Corn			
Fatty foods			
Eggs			
Other foods/spices			
MALE GENITAL	**Mild**	**Mod**	**Severe**
Discharge from penis			
Ejaculation problem			
Erection problem			
Genital pain			
Impotence			

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Lump in testicles			
Low libido			
Decreased endurance			
Weak orgasm			
DERMATOLOGY	**Mild**	**Mod**	**Severe**
Eczema/Psoriasis			
Herpes (genital/oral)			
Hives			
Jock itch/ athletes foot			
Anal itching			
Oily skin			
Rashes			
Red face/cheeks			
Shingles			
Dark spots			
DERM (CONT)	**Mild**	**Mod**	**Severe**
Light/white spots			
Strong body odor			
Excessive sweat			
Lack of sweating			
Cysts under skin			
Calluses/thickening			
Dandruff			
Losing hair (head)			
Losing body hair			
Hair brittle/dry			
Excessive body hair			
Excessive facial hair			
Acne			

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Brittle nails			
Thickening nails			
Nail fungus			
Pitting/nail ridges			
Frayed nails			

FAMILY HISTORY OF DISEASES/CONDITIONS

CONDITION	MOTHER	FATHER	SIBS	CHILDREN	AUNTS/UNCLES
ALIVE					
DECEASED					
GOOD HEALTH					
POOR HEALTH					
Alcoholism					
Allergies					
Dementia					
Anemia					
Thyroid					
Blood clots					
Diabetes					
Heart disease					
Cancer					
Epilepsy					
Blood pressure					
Kidney disease					
Mental health problems					
Arthritis					
Osteoporosis					
Colitis					
Ulcers					
Stroke					
Genetic diseases					
Obesity					

Patient Name:_____ Date_____

TESTS AND PROCEDURES

DIAGNOSTIC STUDY	**WHEN**	**RESULT**
Colonoscopy		
Barium enema		
CT Scan of abdomen		
CT Scan of head/neck		
Bone mineral density (BMD)		
Chest Xray		
EKG		
MRI		
DIAGNOSTIC STUDY	**WHEN**	**RESULT**
Ultrasound of abdomen		
Ultrasound of pelvis		
Sigmoidoscopy		
Biopsy		
Other (LIST)		

The following social/personal issues exist	**True**	**False**
I have many close friends who support me		
I have experienced abuse/trauma in my home		
I am currently experiencing abuse		
My family understands and supports me in my Current illness		

The following statements are:	**True**	**False**
I felt safe growing up		
I currently have pets in the house		
I currently have pets who are outside only		
I have experienced major loss recently		
I have severe work stress		

Patient Name:_____ Date_____

The following statements are:	**True**	**False**
I have excessively long work hours		
My boss/employer is supportive/understanding		
My religion is a source of strength/comfort		
I have missed more than a month of work in the Past year due to illness/injury		
I have missed more than a week of work in the past Year due to illness/injury		
I have major financial worries		
I have minor financial worries		
There is conflict with my children		
There is conflict with my spouse/partner		
I tend to overeat when stressed		
I tend to smoke/drink when stressed		
I avoid friends when stressed		
I lose my appetite when stressed		
I lose sleep when stressed		
I sometimes have rage when driving		
I sometimes have emotional outbursts with Family/coworkers		
I keep my feelings buried		
I have a healthy diet		
I eat juck food more than twice a month		
I eat too much starch/sugar		

Patient Name:_____ Date_____

The following statements are:	**True**	**False**
I eat too many fatty/fried foods		
I overeat		
I have an excellent well balanced diet		
I can't lose weight no matter how hard I try.		
I have difficulty sticking to a healthy diet		