Integrative Rheumatology Associates, P.C.

Integrative Medicine Health History

Name:_____DOB:_____Today's Date_____

Age:_____ Height:_____ Weight:_____ BMI_____

Name of primary care doctor: _____

……

What are your health goals? Concerns? _____

_____

_____

_____

_____

Medical History (specify year diagnosed): _____

_____

_____

_____

_____

Surgical History (specify year of surgery/procedure): _____

_____

_____

_____

_____

Medications (name, dose, frequency, start date): _____

_____

_____

_____

_____

Vitamins/Supplements/Herbs (name, brand, dose, frequency, manufacturer):

_____

_____

_____

_____

Drug or food allergies (specific reaction): _____

_____

_____

_____

_____

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Family History (immediate family/siblings): _____

_____

_____

_____

_____

Social History:

Married/Single/Divorced/Widowed_____

Children? (Names & ages)_____

_____

Occupation/s_____

Hours/day_____

Do you drink alcohol? How many drinks per day/week/month?_____

Do you drink caffeinated beverages? How many per day?_____

Do you smoke? Yes or No? How many cigarettes per day/week? Quit date?_____

Have you tried to quit in the past? What helped or hurt this process?_____

_____

Have you traveled outside of the U.S. recently?_____

Diet:

Please describe your daily diet: **):** _____

_____

_____

_____

_____

Do you drink soda? (amount, type, frequency)_____

_____

What percentage of your meals are fresh cooked foods vs. pre-packaged? ___
Do you go on “diets” often? _____
How many servings of fruit and/or vegetables do you eat per day/week? _____
How many servings of fish do you eat per day/week/month?_____
Do you have “sensitivities” to certain foods? _____
Do you prefer foods that are salty or sweet? _____

Caffeine:
How many caffeinated beverages/foods do you drink per day/week? _____

What kinds of caffeinated drinks do you consume? _____
What time in the day do you typically drink/eat caffeinated products?_____

Exercise/Physical Activity:
Please describe type, duration and frequency:
_____
_____
_____
Do you belong to a gym? How often do you go? _____
Do you have access to a swimming pool? _____
What exercise would you like to try? _____
Any old injuries? _____

Sleep:
How many hours do you typically sleep per night? _____
Do you have difficulty falling asleep? _____
Do you wake up in the middle of the night? How many times? _____
Do you feel “rested” in the morning? _____
Do you take something to fall asleep? Pills? Tea? _____
_____

Do you snore? If yes, do you snore on your side/back/both positions?_____
_____
Do you use a CPAP machine? When did you start? _____
Does your partner snore? Do you sleep in the same room? _____
_____
Do you sleep with children/pets/ a computer in your bedroom? _____
Does stress typically effect your sleep? _____

Stress:
How often do you feel "stressed"? _____
_____
Do you feel that you have control over your stress?_____
_____
Do you take any medications for stress/anxiety? _____
_____
_____

Do you take any herbals/sleep supplements? _____
_____
_____
Is there a family history of anxiety? Depression? Suicide? _____
_____
_____

Have you ever seen a therapist? When? How often? Last time seen?_____
_____
_____
_____
_____

Have you ever tried massage/guided imagery/biofeedback/acupuncture/breathing exercises? _____
_____
_____
_____

Do you tend to eat more when you are "stressed", or less?_____

Environment:

Do you work with any harsh or toxic chemicals?_____
_____

Do your hobbies involve any chemicals? (painting, gardening etc.) _____
_____
_____

How old is the house that you live in? _____

Do you live near a busy road or highway? How long? _____
_____

Which cosmetics do you wear? Personal care products? _____

_____

Which cleaning products do you use? _____

_____
_____
_____
_____

Do you work with any harsh/toxic cleaning products? Industrial chemicals? _____
_____
_____

Spirituality:

Please specify your spiritual beliefs/religious affiliation (optional): _____
_____
_____
_____

Who or what gives you emotional support? _____

_____

When have you been most happy? What makes you happy now? _____
_____
_____

What has been your greatest disappointment/regret in life?_____
_____
_____
_____
What has been your greatest challenge? _____
_____
_____

What has been your greatest source of pride/joy? _____
_____
_____
_____
_____
Anything else you would like to share? _____
_____
_____
_____
_____
_____
_____
_____

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