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Adult Health History

Name:
Date of Birth: **Age:**
Preferred Phone:
Today's Date:

Please answer the following questions as candidly and completely as possible. This will facilitate an open discussion of your wellness goals at your approaching appointment.

List two (present) concerns that you wish to address at your appointment:
1.
2.

Problem #1

Symptoms:
Prior Treatments:
Results of Treatments (circle): Excellent Good Fair Poor
What makes it better?
What makes it worse?

Problem #2

Symptoms:
Prior Treatments:
Results of Treatments (circle): Excellent Good Fair Poor
What makes it better?
What makes it worse?

What was the trigger for your health change?

Prescribed Medications **(Please check medication bottles for correct name and dose of medication).**

Name of Drug and dose	Times taken Each day	Diagnosis (reason for taking)	When did you start taking this drug?	Are you still taking this medication?

Over the Counter (OTC) Medications

Name of Drug and dose	Times taken Each day	Diagnosis (reason for taking)	When did you start taking this drug?	Are you still taking this medication?

Supplements/Vitamins/Herbs

Name of Drug and dose Include Brand	Times taken Each day	Diagnosis (reason for taking)	When did you start taking this drug?	Are you still taking this medication?

Please list all allergies and reactions to medications:

Drug/Medication/Supplement:	Reaction (in detail)

Please list all allergies and reactions to substances/foods etc.:

Substance, food, etc.:	Reaction (in detail)

Vaccines

Are you up to date on all vaccines?	YES	NO	
Do you get a yearly flu vaccine?	YES	NO	
Would you like to be tested for hepatitis C?	YES	NO	
Were you breastfed?	YES	NO	Not sure
Were you born vaginal delivery?	YES	NO	Not sure

Injuries:

Please list any injuries, treatments and outcomes.

Injury:	Date:	Treatment	Treating Physician	Past	On-going

Check Box If you have:	Medical History Please check/circle all that apply:
	Metabolic Syndrome or Pre-Diabetes
	Type 2 Diabetes Mellitus
	Type 1 Diabetes Mellitus
	Hypothyroidism (low thyroid)
	Hyperthyroidism (over-active thyroid
	Polycystic Ovarian Syndrome (PCOS)
	Infertility
	Weight issues (gain)
	Eating disorders (bulimia/anorexia)
	Eating disorder _____
	Endocrine disorder _____
	Heart attack
	Heart disease (angina, CVD)
	Peripheral Vascular disease
	Abnormal heart rhythm
	Hypertension (high blood pressure)
	Stroke or TIA (mini stroke)
	Elevated cholesterol
	Mitral valve prolapse/valve issues
	Varicose veins/phlebitis
	Cancer: (type)
	GERD (esophageal reflux)
	Irritable bowel syndrome (IBS)
	Inflammatory bowel disease (IBD) Crohn's or Ulcerative Colitis
	Celiac disease
	Other GI condition
	Osteoarthritis
	Rheumatoid arthritis
	Fibromyalgia
	Chronic pain
	Other musculoskeletal condition (please describe)
	Gout
	Kidney stones
	Interstitial cystitis
	Frequent bladder/kidney infections
	Frequent yeast infections

	Erectile dysfunction/sexual dysfunction (describe)
	Chronic Fatigue syndrome
	Autoimmune disease (diagnosis)
	Lupus/SLE
	Multiple Sclerosis
	Immune deficiency
	Herpes-Genital
	Communicable disease (HIV, Hepatitis etc.)
	Food allergies
	Environmental allergies
	Multiple chemical sensitivities
	Other allergies:
	Chronic sinusitis (frequent sinus infections)
	Asthma
	Bronchitis
	Emphysema (COPD)
	Pneumonia
	Sleep Apnea (Use of CPAP or BiPAP?)
	Eczema
	Psoriasis
	Acne
	Skin cancer (diagnosis)
	Urticaria (hives)
	Other skin condition
	Blood clots
	Bleeding disorder (diagnosis)
	Depression
	Anxiety
	Bipolar disorder
	Schizophrenia
	Headaches
	Migraines
	ADD/ADHD
	Autism
	Memory problems
	Mild cognitive impairment (diagnosis)

	Parkinson's disease (or tremor disorder)
	Head injury/post-concussion syndrome
	Loss of libido/sex drive (men/women)
	Fibrocystic breast (women)
	Uterine fibroids (women)
	Endometriosis (women)
	Osteoporosis
	Other:

Women's Medical History: Please indicate (circle or check) below:

Are you or do you think you may be pregnant? YES NO	**Do you use birth control? YES NO Type: _____**
Age of Menarche (first period) _____ Age at Menopause _____	Number of pregnancies _____ Number live births _____
Number of Miscarriages/abortion: _____	Regular Menses? YES NO
Days of bleeding _____ Days between periods _____	Check symptoms that you may have during or before your period:
Check symptoms that you may have if you are menopausal: ○ Hot flashes ○ Mood swings ○ Concentration or memory issues ○ Vaginal dryness ○ Painful intercourse ○ Incontinence	○ Cramping ○ Blood clots ○ Breast tenderness ○ PMS ○ Bloating ○ Nausea ○ Diarrhea/constipation ○ Heavy flow
Indicate Last Menstrual Period:	
Do you use hormone therapy? YES NO	How long?
Last Mammogram (date):	Normal? Yes No Breast biopsy?
Last PAP (date):	Normal pap Abnormal pap
Obstetrical complications: YES NO	
Check if you have ever had complications during pregnancy/childbirth:	○ C-section ○ Large baby (over 8lbs) ○ Gestational Diabetes ○ Miscarriage ○ Post-partum depression

Surgical History:

Please indicate whether you have ever had a medical problem and/or surgery/procedure related to each of the following by checking the appropriate boxes. If you have had a medical condition, please note diagnosis, type of surgery, and year of surgery/procedure and complications, if any.

Condition	**Check If "yes"**	**Year**	**Describe surgery procedure/treatment**	**Complications/ Comments**
Eyes Cataract/Lens?				
Ear, nose, sinus Tonsils				
Thyroid (cancer, condition, surgery, biopsy, etc.)				
Heart valves/ablation				
Heart attack, stent, clip				
Arteries (aorta, head, neck, Limbs, bypass etc.)				
Veins, blood clots, varicosities (DVT/PE)				
Lung				
Appendix, esophagus, stomach.				
Intestine (large/small), anus				
Liver/gallbladder				
Hernia				
Kidney/bladder				
Bones, joints, muscles				
Back, spine				
Brain				
Skin				
Breast				
Female: uterus, tubes, ovary, cervix				
Male: prostate, penis, testes				
Other surg/procedure/treatment				

Medical History:

Please list any other medical illness or conditions, including the year of onset, hospitalizations, treatments and other details.

Diagnosis or Condition	Year of Onset	Details of Diagnosis (treatments, physician, hospitalizations etc.)

Dental History:

Please list dental conditions and treatments:

Diagnosis/Condition	Treatment	Ongoing/ Past

Social History:

Answer/Circle

Have you ever used tobacco in any form? Yes No
If yes, what type of tobacco product:
Do you vape? Yes No Type:
Illegal drugs? Yes No Marijuana use? Yes No
When was the last use of any tobacco product?
If you drink alcohol: glasses day/week type of alcohol:
Do you feel you should cut down on alcohol or tobacco? Yes No
What is your occupation? _____ years
Previous occupation? _____ years
Education: Highest level achieved:
Marital status: single married divorced separated live-in
How many years in your relationship? _____ years.
Do you feel safe in your relationship? Yes No
Are you sexually active? Yes No Homosexual? Yes No
Are you experiencing problems with sexual functioning? Yes No
Please explain:

Family History: Please answer to the best of your ability:

Please check family members with all medical conditions listed.	Mother	Father	Mat GM	Mat GF	Pat GM	Pat GF	Sibling	Sibling	Sibling	Sibling	Child	Child	Other:	Other:	Other:
Birth year															
Age at death:															
Alcohol abuse															
Anemia															
Asthma, Atopy or chronic allergies.															
Bleeding disorder															
Blood clots (DVT or PE)															
Cancer*															
Chemical or drug dependency															
Cardiac Disease: cardiovascular, heart attack, congestive heart failure, peripheral vascular disease, valves etc.*															
Diabetes															
Epilepsy/seizures															
Gallbladder															
Glaucoma															
Gastro-intestinal issues*															
Hepatitis/jaundice/liver disease															
High blood pressure (hypertension)															
Immune disorder*															
Kidney disease/failure															
Lung issues (COPD, emphysema) *															
Lupus (SLE)															
Migraines (headaches)															
Osteoarthritis															
Psychiatric disorder															
Rheumatoid arthritis															
Stroke (or mini stroke)															
Thyroid disease															
Other (list):															
Other (list):															
***List:**															
***List:**															

Activity and Nutrition: Please write in or circle your answer to the best of your knowledge. You may indicate more than one answer.

What is your water source?	Well Public bottled filtered
Caffeine Intake: How many cups of coffee/soda/caffeine/chocolate	_____ per day _____days per week
What type of artificial sweetener?	Aspartame Splenda Equal Stevia Truvia NutraSweet Other _____
What type of sugar?	Table sugar Coconut sugar Agave honey Raw honey other _____
Soda/juice/iced tea/sweetened drinks? YES NO	List: How many ounces _____per day.
Deep Fried foods? YES NO	How often? _____/day _____/week
Red Meat? YES NO	Grass Fed? YES NO How often? _____/day _____ /week
Vegetables daily? YES NO	How many servings? _____/day_____/week
Fruit daily? YES NO	How many servings? _____/day _____/week
What percent of your produce is organic?	_____% Do you wash your produce? YES NO
Do you eat fish? YES NO	How often? _____/week
Types of fish (please list):	Wild caught? YES NO
Sweets? YES NO	How often? _____/day _____week
Bread/pasta/white potatoes/rice? YES NO	How often? _____/day _____week
Do you eat processed/frozen/pre-packaged foods?	How often? _____/day _____/week Please list examples:
How often do you eat out?	_____days per week.
Describe a typical diet in a day:	Breakfast:
Lunch:	Dinner:
Snacks:	Beverages/other:
Are you responsible for shopping/cooking?	YES NO
What are your diet/nutritional goals?	List:

Exercise History: Please write in or circle your answer to the best of your knowledge. You may indicate more than one answer.

Do you exercise daily? YES NO	How often? _____days/week
Would you like to start an exercise program?	YES NO
Have you had cardiac testing in the past?	YES NO
Please list testing and results:	Type of test: Results:
Do you feel physically fit? YES NO	Explain:

Environmental History: Please write in or circle your answer to the best of your knowledge. You may indicate more than one answer.

List brands/types of Cleaning products in your home:	Cleaning products:
List brands/types of Cosmetics used:	
List brands/types of Personal products used:	
Do you have any knowledge of chemical/toxic exposures? YES NO	Please list:

Spiritual History: Please write in or circle your answer to the best of your knowledge. You may indicate more than one answer.

List sources of JOY in your life:
What are some DISAPPOINTMENTS in your life?
What are some of your greatest CHALLENGES in your life?
What are your spiritual beliefs and/or religious affiliation:
What are your health and wellness concerns?
What are your health and wellness goals?

Most importantly, who referred you to this practice?

Name:	Phone:
Address:	
May I communicate a "Thank you" to this person?**	YES NO

**Client medical information is NEVER shared with referral source unless he/she is your treating physician.

Review of Symptoms
Circle symptoms. Feel free to add a brief comment .
Weight gain/loss (circle)
Fever/chills/sweats
Night sweats
Appetite increase/decrease
Fatigue
Generalized weakness
Generalized pain/ache/discomfort/spasm
Head/Eyes/Ears/Throat
Head injury (anytime in life) Date: _____
Headache or Migraine (circle)
Hearing changes. Describe:
Ear pain/discharge/bleeding/trauma (circle) Date: _____
Ringing in ears. Date started: _____
Vision or eye changes/trauma/conditions/blindness/dryness/redness. Please describe:
Nasal/sinus congestion/pain/frequent infections
Nose bleeds
Gum bleeding/disease/dry mouth
Sore throat (frequent)
Difficulty swallowing
Chronic hoarseness
non-healing mouth sores
cold sores
thrush
nasal polyps
hearing aid
grinding teeth
Neck
pain/stiffness/reduced movement/swollen glands (circle)
Respiratory
Asthma/COPD/emphysema/chronic bronchitis (circle)
Cough/wheezing/phlegm/sputum/blood
Frequent pneumonia
Cardiovascular (Heart and blood vessels)
Chest pain/tightness/discomfort/palpitations (circle)
Difficulty breathing while laying flat. How many pillows at night? _____
Sleep with fan on or window open
Leg swelling/varicose veins/phlebitis/cramping/calf pain (circle and/or describe)

Irregular heartbeat
Peripheral vascular disease
Blood clots/DVT/PE Date:_____ Treatment:_____
Are you on blood thinners? Name of blood thinner: _____
Anemia. Type: _____
Easy bleeding/bruising
Gastrointestinal (Digestive Tract)
Difficulty swallowing
Easily full
Abdominal pain after meals
Irritable bowel with constipation/diarrhea (Circle)
frequent constipation/diarrhea (Circle)
Blood in stool: dark tarry/bright red/brown or black blood (Circle)
Rectal pain/bleeding/hemorrhoids/fistula (Circle)
Stomach ulcer/bleed (Circle)
Yellow eyes/skin
Liver/Gallbladder problems
Neurologic (Nervous system)
Dizziness/fainting/seizures/brain injury/stroke/LOC (Circle all that apply)
Limb weakness/tremor/numbness/tingling (Circle all that apply)
Paralysis. Describe: _____
Facial droop/numbness/pain/weakness
Endocrine (Hormone)
Excessive thirst/hunger (Circle)
Heat/cold intolerance (Circle)
Urinary
Urination that is frequent/urgent/painful/burning/blood/pressure/fullness (Circle)
Incontinence. Describe: _____
Nocturia. How many times each night: _____
Incomplete bladder empty or weak stream (Circle)
Frequent urinary tract infections.
Psych/Mental
Grief/depression/apathy/irritable/restless/sad/quick temper (Circle all that apply)
Difficulty concentrating/poor memory/frequent forgetfulness/foggy brain
Social Phobia/Poor relationships Thoughts of Suicide?
Stress/nervousness/anxiety/panic attacks/post-traumatic (Circle all that apply)
Sleep
Difficulty falling/staying asleep (Circle)
Snoring/restless legs/nightmares Sleep apnea/Use CPAP or BiPAP