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Weaving Internal Medicine with Alternative Medicine to Use the Best Each Has to Offer

MEDICAL HISTORY FORM

Name: ______________________________ Occupation: ____________________________________

Height: __________ Weight: __________ Birth date: _______________ Blood Type: ___________

How did you hear about us? (List all sources.) ____

NOTE: If you need additional space for any question, use the back of the page and write the question number next to your comments.

1. Describe your current health concerns (include onset, duration, frequency, severity, changes, etc.)

2. Current medications:

3. List of previous medications:

4. Surgery/Scars:

5. Dental History:

Silver fillings	____	TMJ	____	Implants	____
Root Canal	____	Periodontal Disease	____	Bridge	____
Gum Problem	____	Dentures	____	Others	____

6. What kind of health services—therapy, treatment, health practice do you seek?

7. Childhood illnesses including high fevers:

8. Sudden weight gain (unexplained) or losses (other than dieting):

9. Severe stresses/emotional traumas (current & past):

10. INDICATOR CHECK LIST

Indicator	Yes	No
Cold hands and/or feet	Y	N
Cold intolerance	Y	N
Dry skin	Y	N
Dizziness after standing quickly	Y	N
Brittle/dull/dry hair	Y	N
Brittle/peeling fingernails	Y	N
Sleep disturbances	Y	N
Grogginess upon waking	Y	N
Difficulty relaxing	Y	N
Poor concentration/memory	Y	N
Frequent urination	Y	N
Hard, dry, thin, strained stools	Y	N
Loose, frequent, watery stools	Y	N
Gas	Y	N
Mood swings	Y	N
Ringing in the ears	Y	N
Eczema	Y	N
Fluid retention	Y	N
Low or absent sweating	Y	N
Bruise easily	Y	N
Muscle tightness and/or inflexibility	Y	N
Joint stiffness/aching/swelling	Y	N
Headaches	Y	N
Glasses for distance/reading	Y	N

WOMEN ONLY

Indicator	Yes	No
Menstrual cramping	Y	N
PMS	Y	N
Menopause	Y	N
Childbirths	Y	N
Miscarriages(s)/Abortion(s)	Y	N
Decreased libido	Y	N

MEN ONLY

Indicator	Yes	No
Nighttime urination	Y	N
Difficulty starting/stopping urine	Y	N
Slow or interrupted stream	Y	N
Decreased libido	Y	N

11. Diet: Check if applicable:

1) Crave certain foods ____
2) Avoid certain foods ____
3) Skip meals ____
4) Use “fast” foods ____
5) Elimination diet(s) ____
6) Caveman/Atkins diet ____
7) Cook from scratch ____
8) Vegetarian diet ____
9) Eat daytime snacks ____
10) Eat bedtime snacks ____
11) Rotation diet(s) ____
12) Over indulge food(s) ____
13) Reaction to foods ____
14) Candida diet ____
15) Macrobiotic diet ____
16) Low fat diet ____

12. Other – List any concerns not mentioned in any question above: (e.g., problems with vaccination/travel related illness/etc.)

13. What, if any, were your Mother's health problems during pregnancy with you and/or any difficulties during labor and delivery or the neonatal period:

14. List significant medical history in your immediate family:

Mother:

Father:

Siblings:

15. List your current activities/exercise (specify frequency, duration, and time(s) of day):

16. Drops in energy: Y N If yes, at what time(s) of day_________________

17. Place an "x" in the blanks if any of the following apply to your emotional state.

	Now	Past		Now	Past
Anxiety	_____	_____	Indecision	_____	_____
Fear	_____	_____	Frustration	_____	_____
Irritability	_____	_____	Grief/Loss	_____	_____
Anger	_____	_____	Loss of sex drive	_____	_____
Boredom	_____	_____	Excessive stress	_____	_____
Loneliness	_____	_____	Depression	_____	_____

18. List ALL the foods/fluids/beverages you eat & drink each day, including the time of day and average amounts:

Time	Foods	Fluids/Beverages
_____ Breakfast		
_____ Lunch		
_____ Dinner		
_____ Snacks		

How many glasses of water do you regularly drink on a daily basis? _____

Do you drink filtered water? _____

19. Salt Use:
    1. Do you use salt? Yes / No
    2. At each meal? Yes / No
    3. Use Iodized salt /sea salt?
    4. My current salt use is: Low—Moderate—Heavy—By taste.

20. Do you diet now? Yes / No ==>> Have you ever dieted? Yes / No ==>> If Yes, please explain:

21. List all supplements you currently take:

22. Do you have an air filter system in your Home? ______ Car? _____ Office? _____

23. Do you use or have you used:

	Now	Past		Now	Past
Alcohol	____	____	Marijuana	____	____
Cocaine	____	____	Diet Pills	____	____
Laxatives	____	____	Cigarettes/Tobacco	____	____
Birth Control Pill	____	____	Hallucinogens	____	____

24. What are your goals in coming to Prevention and Healing, Inc?

25. Any other comments? (Use the back of this page if necessary.)

______________________________ ______________________

Signature Date