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Weaving Internal Medicine with Integrative 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 (mark all that apply, and/or insert number of each):

Silver Fillings	_____	TMJ	_____	Implants	_____
Root Canals	_____	Periodontal Disease	_____	Bridge	_____
Gum Problems	_____	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	Yes	No.
Cold hands and/or feet		
Cold intolerance		
Dry skin		
Dizziness after standing quickly		
Brittle/dull/dry hair		
Brittle/peeling fingernails		
Sleep disturbances		
Grogginess upon waking		
Difficulty relaxing		
Poor concentration/memory		
Frequent urination		
Hard, dry, thin, strained stools		
Loose, frequent, watery stools		
Gas		
Mood swings		
ringing in the ears		
Eczema		
Fluid retention		
Low or absent sweating		

Bruise easily
Muscle tightness and/or inflexibility
Joint stiffness/aching/swelling
Headaches
Glasses for distance/reading

WOMEN ONLY

Menstrual cramping
PMS
Menopause
Childbirths
Miscariages(s)/Abortion(s)
Decreased libido

MEN ONLY

Nighttime urination
Difficulty starting/stopping urine
Slow or interrupted stream
Decreased libido

11. Diet: Check if applicable:

1) Crave certain foods	_____	9) Eat daytime snacks	_____
2) Avoid certain foods	_____	10) Eat bedtime snacks	_____
3) Skip meals	_____	11) Rotation diet(s)	_____
4) Use "fast" foods	_____	12) Over indulge food(s)	_____
5) Elimination diet(s)	_____	13) Reaction to foods	_____
6) Paleo/Atkins diet	_____	14) Candida diet	_____
7) Cook from scratch	_____	15) Macrobiotic diet	_____
8) Vegetarian 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 foods/fluids/beverages you eat & drink each day, note time of day and average amounts:

<u>Time</u>	<u>Foods</u>	<u>Fluids/Beverages</u>
_____ 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? Yes / No
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