Prevention & Healing

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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	○	○
Miscarriages(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:

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? 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.)

Note: Fill in this form above, print, sign by hand, and bring to your appointment (or mail in advance).

_____ _____
Signature Date