Personal Health History

_____

Patient Name

1. Height
2. Weight

To determine your present state of health, please mark yes or no as it applies to each condition:	**Yes**	**No**
1. Headaches (migraine, cluster, tension)	□	□
2. Neurological disorder (epilepsy, seizure, stroke)	□	□
3. Lung disorders (asthma, pneumonia, bronchitis, emphysema)	□	□
4. Heart disease (atherosclerosis, angina, heart failure, heart attack, stroke)	□	□
5. Hypertension (high blood pressure)	□	□
6. Hyperlipidemia (high cholesterol)	□	□
7. Peptic ulcer / reflux esophagitis / pancreatitis	□	□
8. Irritable bowel disease / Crohn's disease/ Ulcerative Colitis	□	□
9. Liver or gall bladder disease-Hepatitis, Fatty Liver, Cirrhosis	□	□
10. Edema or excess fluid retention	□	□
11. Insulin resistance or diabetes (Type I / Type II)	□	□
12. Thyroid disease	□	□
13. Other hormonal deficiencies including growth hormone	□	□
14. Arthritis or joint problems including herniated disc	□	□
15. Musculoskeletal problems including osteoporosis	□	□
16. Cancer > if yes, what type(s) of cancer, date(s), treatment type(s)	□	□
17. Have you had any other medical problems that have been diagnosed by other health care professionals? Please describe:	□	□

Have you recently experienced any of the following conditions?

Condition	Yes	No	Condition	Yes	No
18. Loss of concentration, sociability, activity	□	□	31. Dry skin	□	□
19. Decreased short term memory	□	□	32. Brittle nails	□	□
20. Decreasing desire or ability to exercise	□	□	33. Dry eyes	□	□
21. Decreasing sense of well-being	□	□	34. Hair loss	□	□
22. Loss of interest in/or desire for sex	□	□	35. Chest pains	□	□
23. Cold or heat intolerance	□	□	36. Palpitations	□	□
24. Indigestion or difficulty swallowing	□	□	37. Swelling of ankles	□	□
25. Stomach pain	□	□	38. Easily tired	□	□
26. Belching	□	□	39. Night sweating	□	□
27. Heartburn	□	□	40. Unusual or excessive sweating	□	□
28. Bloating after meals	□	□	41. Difficulty breathing; at rest	□	□
29. Diarrhea	□	□	42. Difficulty breathing; during activity	□	□
30. Constipation	□	□			

43. Have you had any surgeries? (If yes, please describe)

Surgery	Year	Reason

44. Have you had any other hospitalizations? (If yes, please describe)

Hospitalization	Year	Reason

45. Are you allergic to any medications? (If yes, please describe)

Drug	Reaction

46. Do you take any prescribed or over the counter drugs or supplements? (Please describe)

Medication or Supplement	Dose	Frequency

Please answer the following:	Yes	No
47. Have you ever had a blood transfusion?	□	□
48. Are you currently dieting to lose weight or for other health reasons?	□	□
49. If you answered yes above, are you on a diet prescribed by a health care professional?	□	□
50. Do you use recreational drugs?	□	□
51. If you answered yes above, have you ever received recreational drugs via a needle?	□	□
52. Are you sexually active?	□	□
53. Do you experience any discomfort with intercourse?	□	□
54. Do you currently use tobacco products? (cigarettes, cigars, pipe, chew, etc.)	□	□

Female Patients please answer the following:

55. Are you pregnant or planning on becoming pregnant? Yes □ No □

56. Do you experience any discomfort with intercourse? Yes □ No □ If yes, please describe

_____

57. Any issues with sexual climax? Yes □ No □

58. Vaginal dryness? Yes □ No □

59. Vaginal discharge? Yes □ No □

60. At what age did you start your Menstrual Cycle? _____

57. Were you menstruating regularly? Yes □ No □ What was frequency of cycle? _____

62. Currently, do you experience any PMS prior to menstruating? Yes □ No □

63. Do you experience cramping? Yes □ No □

64. Menstrual Flow; heavy, light or both? _____

65. Any clots during Menstrual Cycle? Yes □ No □

65. How many days do or did your most recent Menstrual Cycle last? _____

68. How many Menstrual Cycles per month? _____

70. How many tampons/pads do you use during your Menstrual Cycle? _____

58. Have you been on any type of hormone therapy? Yes □ No □ If yes, when and what type?

_____

59. Do you think you are pre-menopausal? Yes □ No □ Post Menopausal? Yes □ No □ or currently in Menopause? Yes □ No □

60. Have you had children? Yes □ No □ If so, how many and where they full term, premature, or miscarriages? Please describe _____

_____

_____

61. Did you deliver vaginally, or did you have C-Section(s)?

_____

62. During your pregnancies; did you experience any high blood pressure or gestational diabetes or asthma or Toxemia or pneumonia? Please describe;

_____

_____

Male Patients please answer the following:

63. Have you had a prostate infection within the last year? Yes □ No □
64. Do you experience any difficulty with erection or ejaculation? Yes □ No □
65. Do you experience any pain during erection or during ejaculation? Yes □ No □
66. Do you or have you ever used medication for erectile dysfunction? If yes, please list;

_____

67. Do you feel any testicular pain or swelling? Yes □ No □
68. Have you had a prostate and/or rectal exam within the last year? Yes □ No □

Both male and female patients, please answer the following as it applies to each condition:	**Yes**	**No**
69. Do you usually get up to urinate during the night?	□	□
70. If you answered yes above, do you get up more than once during the night?	□	□
71. Do you feel pain or burning during urination?	□	□
72. Do you notice, or have you noticed any blood in your urine?	□	□
73. Has the force of your urine stream decreased?	□	□
74. Have you had a kidney or bladder infection within the last year?	□	□
75. Do you experience any problems emptying you bladder completely?	□	□
76. Have you noticed a loss of muscle mass or tone?	□	□
77. Have you noticed an increase in abdominal fat?	□	□
78. Do you feel more hesitant and/or less confident?	□	□
79. Do you feel your sexual performance has declined?	□	□
80. Is your hair thinning or have you noticed hair loss?	□	□
81. Is your skin thinning, less elastic or less supple?	□	□
82. Do you feel it is hard to recover from physical activity?	□	□
83. Do you put on weight easily?	□	□
84. Do you have trouble getting up in the morning?	□	□

To determine you present state of mental health, please mark yes or no as it applies to each condition:	**Yes**	**No**
85. Is stress a major problem for you?	□	□
86. Do you panic when stressed?	□	□
87. Do you have problems with your eating or your appetite as a result of stress?	□	□
88. Do you have trouble sitting still or concentrating as a result of stress?	□	□
89. Do you often have physical symptoms resulting from stress (i.e. upset stomach)?	□	□
90. Have you ever seriously thought about hurting yourself?	□	□
91. Do you have trouble falling asleep or staying asleep?	□	□
92. Do you work excessively?	□	□
93. Do you feel depressed?	□	□
94. Have you ever attempted suicide?	□	□
95. Do you cry frequently?	□	□
96. Are you easily angry or irritable?	□	□
97. Have you ever been to a counselor?	□	□

98. How many times do you eat per day?	Once □	Twice □	Three □	Four □	Five or more □
99. How many servings of fruit do you eat per day?	Less than one □	One □	Two □	Three □	Four or more □
100. How many servings of vegetables do you eat per day?	Less than one □	One □	Two □	Three □	Four or more □
101. How many glasses of water do you drink per day?	Less than one □	One-two □	Three – Four □	Five-Seven □	Eight or more □
102. How many times per day do you eat sweet or sugary foods?	Less than once □	Once □	Twice □	Three □	Four or more □
103. How many times per day do you eat salty foods?	Less than once □	Once □	Twice □	Three □	Four or more □
104. How many times per day do you eat fried/fatty foods?	Less than once □	Once □	Twice □	Three □	Four or more □
105. How many times per week do you consume alcohol?	Less than once □	Once or twice □	Three-Four □	Five – Six □	Seven or more □
106. How much do you exercise?	Never □	Rarely □	Occasionally □	Regularly □	Daily □

Family History:

Your family's health history	Living	Deceased	Age	Significant Health Problem or Cause of Death
1. Father	□	□		
2. Mother	□	□		
3. Brother □ Sister □	□	□		
4. Brother □ Sister □	□	□		
5. Brother □ Sister □	□	□		
6. Brother □ Sister □	□	□		
7. Son □ Daughter □	□	□		
8. Son □ Daughter □	□	□		
9. Son □ Daughter □	□	□		

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education, and promotion.

The information that I have provided is true and accurate to the best of my knowledge.

Patient Signature _____

Date _____