

HEALTH HISTORY

CONFIDENTIAL

NAME (LAST, FIRST, MIDDLE)

DATE

PLEASE CHECK ANY SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR

GENERAL <ul style="list-style-type: none"><input type="radio"/> Cold hands/feet<input type="radio"/> Low energy<input type="radio"/> Dizziness<input type="radio"/> Allergies<input type="radio"/> Fatigue<input type="radio"/> Hot flashes<input type="radio"/> Insomnia<input type="radio"/> Spontaneous sweating<input type="radio"/> Night sweating<input type="radio"/> Lack of sweating<input type="radio"/> Recent weight loss<input type="radio"/> Recent weight gain<input type="radio"/> Aversion to heat<input type="radio"/> Aversion to cold<input type="radio"/> Weak immune system<input type="radio"/> Sleep Apnea	RESPIRATORY <ul style="list-style-type: none"><input type="radio"/> Asthma<input type="radio"/> Persistent cough<input type="radio"/> Coughing blood<input type="radio"/> Shortness of breath<input type="radio"/> Recurrent bronchitis<input type="radio"/> Phlegm production<input type="radio"/> Difficulty inhaling<input type="radio"/> Difficulty exhaling CARDIOVASCULAR <ul style="list-style-type: none"><input type="radio"/> Chest pain<input type="radio"/> High blood pressure<input type="radio"/> Low blood pressure<input type="radio"/> Irregular heart beat<input type="radio"/> Poor circulation<input type="radio"/> Swelling of ankles<input type="radio"/> Varicose veins<input type="radio"/> Rib-side pain GASTROINTESTINAL <ul style="list-style-type: none"><input type="radio"/> Abdominal pain<input type="radio"/> Bloating<input type="radio"/> Belching<input type="radio"/> Gas<input type="radio"/> Constipation<input type="radio"/> Diarrhea/loose stools<input type="radio"/> Bloody stools<input type="radio"/> Black stools<input type="radio"/> Difficulty swallowing<input type="radio"/> Poor appetite<input type="radio"/> Heartburn/acid reflux<input type="radio"/> Hemorrhoids<input type="radio"/> Indigestion<input type="radio"/> Stomach ache<input type="radio"/> Nausea<input type="radio"/> Vomiting<input type="radio"/> Food sensitivities	DIET/LIFESTYLE <ul style="list-style-type: none"><input type="radio"/> Vegetarian<input type="radio"/> Healthy diet<input type="radio"/> Eat fried foods<input type="radio"/> Eat much meat<input type="radio"/> Smoke<input type="radio"/> Drink alcohol<input type="radio"/> Drink coffee<input type="radio"/> Eat a lot of sweets<input type="radio"/> Exercise regularly<input type="radio"/> Exercise excessively<input type="radio"/> Lack of exercise GENITOURINARY <ul style="list-style-type: none"><input type="radio"/> Dilute urine<input type="radio"/> Dark urine<input type="radio"/> Blood in urine<input type="radio"/> Cloudy urine<input type="radio"/> Burning urination<input type="radio"/> Scanty urine<input type="radio"/> Profuse urine<input type="radio"/> Frequent urination<input type="radio"/> Poor bladder control<input type="radio"/> Urgency to urinate<input type="radio"/> Prolapsed bladder MUSCULOSKELETAL <p>Pain, weakness, numbness in:</p> <ul style="list-style-type: none"><input type="radio"/> Arms<input type="radio"/> Feet<input type="radio"/> Hands<input type="radio"/> Joints<input type="radio"/> Legs<input type="radio"/> Hips<input type="radio"/> Neck<input type="radio"/> Shoulders<input type="radio"/> Knees<input type="radio"/> Back<input type="radio"/> Pain all over<input type="radio"/> Lack of strength<input type="radio"/> Numbness	SKIN <ul style="list-style-type: none"><input type="radio"/> Broken blood vessels<input type="radio"/> Blood not clotting<input type="radio"/> Bruise easily<input type="radio"/> Discoloration<input type="radio"/> Dark circles around eyes<input type="radio"/> Bags under eyes<input type="radio"/> Swollen lymph nodes<input type="radio"/> Dry skin<input type="radio"/> Acne<input type="radio"/> Brittle nails<input type="radio"/> Premature gray hair<input type="radio"/> Dry, brittle hair<input type="radio"/> Hair falling out NEUROLOGIC <ul style="list-style-type: none"><input type="radio"/> Fainting<input type="radio"/> Convulsions<input type="radio"/> Handwriting change<input type="radio"/> Paralysis<input type="radio"/> Stroke<input type="radio"/> Seizures<input type="radio"/> Tremor<input type="radio"/> Recent clumsiness<input type="radio"/> Drowsiness<input type="radio"/> Vertigo EMOTIONAL <ul style="list-style-type: none"><input type="radio"/> Nervousness<input type="radio"/> Irritability<input type="radio"/> Depression<input type="radio"/> Troubling dreams<input type="radio"/> Cry uncontrollably<input type="radio"/> Feel sad a lot<input type="radio"/> Forgetful<input type="radio"/> Mind not clear<input type="radio"/> Anxiety<input type="radio"/> Much fear<input type="radio"/> Unrestrained joy<input type="radio"/> Terrors<input type="radio"/> Difficulty expressing emotions<input type="radio"/> Often feel angry	MEN ONLY <ul style="list-style-type: none"><input type="radio"/> Genital pain<input type="radio"/> Impotence<input type="radio"/> Genital sores<input type="radio"/> Lump in testicles<input type="radio"/> Discharge from penis<input type="radio"/> Nocturnal emission<input type="radio"/> Low sexual energy WOMEN ONLY <ul style="list-style-type: none"><input type="radio"/> Abnormal pap smear<input type="radio"/> Bleed between periods<input type="radio"/> Irregular periods<input type="radio"/> Heavy periods<input type="radio"/> Painful periods<input type="radio"/> Premenstrual tension<input type="radio"/> Breast lumps<input type="radio"/> Low sexual energy<input type="radio"/> Vaginal discharges<input type="radio"/> Menopausal<input type="radio"/> Uterine prolapse<input type="radio"/> Facial hair<input type="radio"/> May be pregnant<input type="radio"/> Pain with intercourse<input type="radio"/> Tipped uterus <p>BLOOD TYPE IF KNOWN: _____</p> WEIGHT <ul style="list-style-type: none"><input type="radio"/> Underweight<input type="radio"/> Normal for height<input type="radio"/> Overweight<input type="radio"/> Very overweight
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PLEASE USE THE REVERSE OF THIS FORM TO WRITE DOWN A SAMPLE OF YOUR DAILY DIET: ----->



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