# Medical History Form

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Name: _________________ Middle Name: _______________ Last Name: ____________________

Address: ______________________________ City: _________________ State: _______ ZIP: _________

Home Phone: (________) ________-___________ Birth Date: _____/____/____ Age: ___________
month day year

Work Phone: (________) ________-___________

Place of Birth:______________________________
City or town & country if not US

Occupation: ______________________________

Referred By: ______________________________ Height: ___ft ____ in Weight: _______ Sex: _____

Primary Care Doctor:________________________ Today's Date: _____________________________

1. Please check appropriate box(es):

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European ☐ Other

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

| DESCRIBE PROBLEM | MILD/ MODERATE/ SEVERE | TREATMENT APPROACH | SUCCESS |
|---|---|---|---|
| **Example:** Post Nasal Drip | Moderate | Elimination Diet | Moderate |
| a. | | | |
| b. | | | |
| c. | | | |
| d. | | | |
| e. | | | |
| f. | | | |
| g. | | | |

3. What do you hope to achieve from your visit today? ________________________________________

_______________________________________________________________

# Medical History Form

4. Did something trigger your change in health? ______________________________________________
______________________________________________

5. What makes you feel better? ______________________________________________
______________________________________________

6. What make you feel worse? ______________________________________________
______________________________________________

7. When was the last time you felt well? ______________________________________________
______________________________________________

## MEDICATION HISTORY

8. How often have you have taken antibiotics?

| | **< 5 times** | **> 5 times** |
|---|---|---|
| Infancy/ Childhood | | |
| Teen | | |
| Adulthood | | |

9. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

| | **< 5 times** | **> 5 times** |
|---|---|---|
| Infancy/ Childhood | | |
| Teen | | |
| Adulthood | | |

10. What medications are you taking now? Include non-prescription drugs.

| **Medication Name** | **Date started** | **Dosage** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

11. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

| Vitamin/Mineral/Supplement Name | Date started | Dosage |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

## Allergies

12. Allergies to Medicine/Supplements/Foods

Medication/Supplement/Food ______________________ Reaction ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

## MEDICAL HISTORY

13. Childhood:

| Question | Yes | No | Don't Know | Comment |
|---|---|---|---|---|
| 1. Were you a full term baby? | | | | |
| a. A preemie? | | | | |
| b. Breast fed? | | | | |
| c. Bottle fed? | | | | |
| 2. As a child did you eat a lot of sugar and/or candy? | | | | |

# Medical History Form

14. Past Medical and Surgical History:

| | ILLNESSES | WHEN | COMMENTS |
|---|---|---|---|
| a. | Anemia | | |
| b. | Arthritis | | |
| c. | Asthma | | |
| d. | Bronchitis | | |
| e. | Cancer | | |
| f. | Chronic Fatigue Syndrome | | |
| g. | Crohn's Disease or Ulcerative Colitis | | |
| h. | Diabetes | | |
| i. | Emphysema | | |
| j. | Epilepsy, convulsions, or seizures | | |
| k. | Gallstones | | |
| l. | Gout | | |
| m. | Heart attack/Angina | | |
| n. | Heart failure | | |
| o. | Hepatitis | | |
| p. | High blood fats (cholesterol, triglycerides) | | |
| q. | High blood pressure (hypertension) | | |
| r. | Irritable bowel | | |
| s. | Kidney stones | | |
| t. | Mononucleosis | | |
| u. | Pneumonia | | |
| v. | Rheumatic fever | | |
| | **ILLNESS** | **WHEN** | **COMMENTS** |
| w. | Sinusitis | | |
| x. | Sleep apnea | | |
| y. | Stroke | | |
| z. | Thyroid disease | | |
| aa. | Other (describe) | | |
| | **INJURIES** | **WHEN** | **COMMENTS** |
| ab. | Back injury | | |
| ac. | Broken (describe) | | |
| ad. | Head injury | | |

# Medical History Form

| | | WHEN | COMMENTS |
|---|---|---|---|
| ae. | Neck injury | | |
| af. | Other (describe) | | |
| | **DIAGNOSTIC STUDIES** | **WHEN** | **COMMENTS** |
| ag. | Barium Enema | | |
| ah. | Bone Scan | | |
| ai. | CAT Scan of Abdomen | | |
| aj. | CAT Scan of Brain | | |
| ak. | CAT Scan of Spine | | |
| al. | Chest X-ray | | |
| am. | Colonoscopy | | |
| an. | EKG | | |
| ao. | Liver scan | | |
| ap. | Neck X-ray | | |
| aq. | NMR/MRI | | |
| ar. | Sigmoidoscopy | | |
| as. | Upper GI Series | | |
| at. | Other (describe) | | |
| | **OPERATIONS** | **WHEN** | **COMMENTS** |
| au. | Appendectomy | | |
| av. | Dental Surgery | | |
| aw. | Gall Bladder | | |
| ax. | Hernia | | |
| ay. | Hysterectomy | | |
| az. | Tonsillectomy | | |
| ba. | Other (describe) | | |
| bb. | Other (describe) | | |

15. Hospitalizations:

| WHERE HOSPITALIZED | WHEN | FOR WHAT REASON |
|---|---|---|
| a. | | |
| b. | | |
| c. | | |
| d. | | |
| e. | | |

# Medical History Form

**Gynecological History**

16. Have you ever been pregnant? (If no, skip to question 17.) Yes____ No____
    Number of miscarriages _____ Number of abortions _____ Number of preemies _____
    Number of term births _____ Birth weight of largest baby _____ Smallest baby _____

    Did you develop toxemia (high blood pressure)? Yes____ No____
    Have you had other problems with pregnancy? Yes____ No____
    If so, please comment:______________________________________________________________
    ____________________________________________________________________________________

17. Age at first period _____ Length of cycle ___________ Number of days of flow ___________________
18. Are your periods painful? Yes ___ No____ My flow is Light ____ Medium ____ Heavy ____
19. How many days per cycle are heavy? _____
20. On a heavy day how do you change your pad or tampon? ________________________________
21. Have you ever skipped a period? Yes____ No____ How often? ______________________________
22. Date of Last Menstrual Period: __________________________________________________
23. Date of last Pap Smear _____________ Normal ____ Abnormal _____
24. Date of last Mammogram____________ Normal ____ Abnormal _____
25. Date of Last Bone Density ____________ Results? Normal ____ Low _______
26. Date of Last Cholesterol test ________________ Results ______________________________
27. Have you ever used birth control pills? Yes____ No____ If yes, when _________
28. Are you taking the pill now? Yes____ No____
29. Did taking the pill agree with you? Yes____ No____ Not applicable _____
30. Do you currently use contraception? Yes____ No____
    If yes, what type of contraception do you use? _________________________________________
31. Do you get Migraine Headaches? Yes ____ No____
    If yes, do you experience an aura before the onset of the headache? Yes____ No _____
32. Have you ever been diagnosed with cancer of any type? Yes ___ No ____
    If yes, describe ___________________________________________________________________
33. Have ever had a blood clot in your legs or lungs? Yes ____ No_____
34. Are you in menopause? Yes _____ No _____ If yes, age at last period______

    Do you take: Estrogen? ______ Ogen?___ Estrace?___ Premarin?___
    Progesterone?___ Provera? ___ Other (specify) ____________________________

35. How long have you been on hormone replacement therapy (if applicable)? _________________
36. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? Yes____ No____ Not applicable _____

# Medical History Form

## DIGESTION HISTORY

37. Please fill in the chart below with information about your bowel movements:

| a. Frequency | √ | b. Color | √ |
|---|---|---|---|
| More than 3x/day | | Medium brown consistently | |
| 1-3x/day | | Very dark or black | |
| 4-6x/week | | Greenish color | |
| 2-3x/week | | Blood is visible. | |
| 1 or fewer x/week | | Varies a lot. | |
| | | Dark brown consistently | |
| b. Consistency | | Yellow, light brown | |
| Soft and well formed | | Greasy, shiny appearance | |
| Often float | | | |
| Difficult to pass | | | |
| Diarrhea | | | |
| Thin, long or narrow | | | |
| Small and hard | | | |
| Loose but not watery | | | |
| Alternating between hard and loose/watery | | | |

38. Foreign Travel? Yes ____ No____
When/Where?______________________________________________________________________

______________________________________________________________________________

39. Wilderness Camping? Yes ___ No_____ When/Where? ______________________________________

40. Intestinal gas: Daily ________________ Present with pain ______________
Occasionally_________ Foul smelling ________________
Excessive ____________ Little odor ____________________

41. Do you feel you digest your food well? Yes____ No____

## Nutrition History

42. Have you ever had a nutrition consultation? Yes____ No______
43. Have you made any changes in your eating habits because of your health? Yes ____ No_____

Describe_______________________________________________________________________
_______________________________________________________________________________

# Medical History Form

44. As a child, were there any foods that you had to avoid because they gave you symptoms? Yes____ No____

If yes, please: name the food and symptom (Example: milk – gas and diarrhea) ___________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

45. Are you on a special diet? Yes____ No____

_____ ovo-lacto
_____ diabetic
_____ dairy restricted
_____ vegetarian
_____ vegan
_____ blood type diet
_____ other (describe):
____________________________
____________________________

46. Is there anything special about your diet that we should know? Yes____ No____
If yes, please explain: ___________________________________________________________________________

47. a. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.? Yes____ No____
b. If yes, are these symptoms associated with any particular food or supplement(s)? Yes____ No____
c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

_______________________________________________________________________________________________

_______________________________________________________________________________________________

48. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes____ No____

49. Do you feel much **worse** when you eat a lot of:

______high fat foods
______high protein foods
______high carbohydrate foods
(breads, pastas, potatoes)
_______refined sugar (junk food)
_______fried foods
_______1 or 2 alcoholic drinks
_______other ______________________________

50. Do you feel much **better** when you eat a lot of:

______high fat foods
______high protein foods
______high carbohydrate foods
(breads, pastas, potatoes)
_______refined sugar (junk food)
_______fried foods
_______1 or 2 alcoholic drinks
_______other ______________________________

51. Does skipping a meal greatly affect your symptoms? Yes____ No____

52. Have you ever had a food that you craved or really "binged" on over a period of time?
Food craving may be an indicator that you may be allergic to that food. Yes____ No____
If yes, what food(s)? ______________________________________________________________________________

_______________________________________________________________________________________________

53. Do you have an aversion to certain foods? Yes____ No____
If yes, what foods? ____________________________________________

## SOCIAL HISTORY

54. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
Example: Wendy, age 7, sister ____________________________________________
____________________________________________
____________________________________________

55. How well have things been going for you?

| | Very Well | Fair | Poorly | Very Poorly | Does not apply |
|---|---|---|---|---|---|
| a. At school | | | | | |
| b. In your job | | | | | |
| c. In your social life | | | | | |
| d. With close friends | | | | | |
| e. With sex | | | | | |
| f. With your attitude | | | | | |
| g. With your boyfriend/girlfriend | | | | | |
| h. With your children | | | | | |
| i. With your parents | | | | | |
| j. With your spouse | | | | | |

56. Have you ever had psychotherapy or counseling? Yes____ No____
Currently? _____ Previously? _____ If previously, from ______ to _______.
What kind? ____________________________________________
Comments:____________________________________________

57. Are you currently, or have you ever been, married? Yes____ No____
If so, when were you married? __________ Spouse's occupation __________________
When were you separated? __________ Never _____
When were you divorced? __________ Never _____
When were you remarried? __________ Never _____ Spouse's occupation __________________
Comments: ____________________________________________

58. Hobbies and leisure activities:____________________________________________
____________________________________________

# Medical History Form

59. Have you or your family recently experienced any major life changes? Yes____ No____

    If yes, please comment: ____________________________________________________________
    ____________________________________________________________________________

60. Have you experienced any major losses in life? Yes____ No____
    If so, please comment: ____________________________________________________________
    ____________________________________________________________________________

61. How important is religion (or spirituality) for you and your family's life?
    a. _____ not at all important
    b. _____ somewhat important
    c. _____ extremely important

62. How much time have you lost from work or school in the past year?
    a._____ 0-2 days
    b. _____ 3 –14 days
    c. _____ > 15 days

63. List your previous jobs____________________________________________________________
    ____________________________________________________________________________

64. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

    Please do your best to answer the following questions:

    a. Did you feel safe growing up?
       ☐ Yes ☐ No
    b. Have you been involved in abusive relationships in your life?
       ☐ Yes ☐ No
    c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
       ☐ Yes ☐ No
    d. Do you currently feel safe in your home?
       ☐ Yes ☐ No
    e. Do you feel safe, respected and valued in your current relationship?
       ☐ Yes ☐ No
    f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
       ☐ Yes ☐ No

# Medical History Form

## HABITS

65. a. Have you ever used alcohol? Yes____ No____
    b. If yes, how often do you now drink alcohol?
    ___ No longer drinking alcohol
    ___ Average 1-3 drinks per week
    ___ Average 4-6 drinks per week
    ___ Average 7-10 drinks per week
    ___ Average >10 drinks per week
    c. Have you ever had a problem with alcohol? Yes____ No____
    If yes, please indicate time period (month/year): from ________ to ___________.

66. Have you ever used recreational drugs? Yes____ No____
67. Have you ever used tobacco? Yes____ No____
    If yes, number of years as a nicotine user _____. Amount per day _____. Year quit _____.
    If yes, what type of nicotine have you used? Cigarette ________ Smokeless ______________
    Cigar _____Pipe _____Patch/Gum _______

## ENVIRONMENTAL AND DETOXIFICAITON HISTORY

68. Are you exposed to second hand smoke regularly? Yes____ No____
69. Do you have mercury amalgam fillings? Yes____ No____
70. Do you have any artificial joints or implants? Yes____ No____
71. Do you feel worse at certain times of the year? Yes____ No____
    If yes, when? ________spring ________fall
    ________summer ________winter
72. Do you have now adverse food reactions or sensitivities? Yes ____ No ____ Describe____________________
    ________________________________________________________________________________
73. Does caffeine make you not feel well? Yes ____ No ____
74. Have you, to your knowledge, been exposed to toxic metals in your job or at home? Yes____ No____
    If yes, which one(s)? ________lead __________cadmium
    ________arsenic __________mercury
    ________aluminum
75. Do you have a known history of significant exposure to any harmful chemical such as the following:
    Herbicides ____ Insecticides (frequent visits of exterminator) Pesticides _____ Organic solvents ______
    Heavy Metals ____ Other ______________________________________________________________
76. Do you dry clean your clothes frequently? Yes ____ No____
77. Have you ever been told you have Gilbert's Disease or other liver disorder? Yes ____ No____
78. Have you ever turned yellow (jaundice)? Yes ____ No ____
79. Do odors affect you? Yes____ No____
80. Do you have any pets or farm animals? Yes____ No____
    If yes, where do they live? _____ indoors _____ outdoors _____ both indoors and outdoors

## EXERCISE HISTORY

81. Do you exercise regularly? Yes____ No____
    If so, how many times a week? ____1x ___2x ____3x ___4x or more

    When you exercise, how long is each session?
    1.__ ≤15 min
    2.__ 16-30 min
    3.__ 31-45 min
    4.__ > 45 min

    What type of exercise is it?

    | | |
    |---|---|
    | ___jogging/walking | ____tennis |
    | ___basketball | ____water sports |
    | ___home aerobics | ____other ________________________ |

# Medical History Form

Please check if these symptoms occur presently **or** have occurred in the past 6 months.

| **GENERAL:** | **Mild** | **Mod-erate** | **Severe** |
|---|---|---|---|
| Cold hands & feet | | | |
| Cold intolerance | | | |
| Daytime sleepiness | | | |
| Difficulty falling asleep | | | |
| Early waking | | | |
| Fatigue | | | |
| Fever | | | |
| Flushing | | | |
| Heat intolerance | | | |
| Night waking | | | |
| Nightmares | | | |
| No dream recall | | | |
| **HEAD, EYES & EARS:** | | | |
| Conjunctivitis | | | |
| Distorted sense of smell | | | |
| Distorted taste | | | |
| Ear fullness | | | |
| Ear noises | | | |
| Ear pain | | | |
| Ear ringing/buzzing | | | |
| Eye crusting | | | |
| Eye pain | | | |
| Headache | | | |
| Hearing loss | | | |
| Hearing problems | | | |
| Lid margin redness | | | |
| Migraine | | | |
| Sensitivity to loud noises | | | |
| Vision problems | | | |

| **MUSCULOSKELETAL:** | **Mild** | **Mod-erate** | **Severe** |
|---|---|---|---|
| Back muscle spasm | | | |
| Calf cramps | | | |
| Chest tightness | | | |
| Foot cramps | | | |
| Joint deformity | | | |
| Joint pain | | | |
| Joint redness | | | |
| Joint stiffness | | | |
| Muscle pain | | | |
| Muscle spasms | | | |
| Muscle stiffness | | | |
| Muscle twitches: Around eyes | | | |
| Arms or legs | | | |
| Muscle weakness | | | |
| Neck muscle spasm | | | |
| Tendonitis | | | |
| Tension headache | | | |
| TMJ problems | | | |
| **MOOD/NERVES:** | | | |
| Agoraphobia | | | |
| Anxiety | | | |
| Auditory hallucinations | | | |
| Black-out | | | |
| Depression | | | |
| Difficulty: Concentrating | | | |
| With balance | | | |
| With thinking | | | |
| With judgment | | | |
| With speech | | | |
| With memory | | | |
| Dizziness (spinning) | | | |
| Fainting | | | |
| Fearfulness | | | |
| Irritability | | | |
| Light-headedness | | | |

# Medical History Form

| MOOD/NERVES, Cont'd: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Numbness | | | |
| Other Phobias | | | |
| Panic attacks | | | |
| Paranoia | | | |
| Seizures | | | |
| Suicidal thoughts | | | |
| Tingling | | | |
| Tremor/trembling | | | |
| Visual hallucinations | | | |
| **EATING:** | | | |
| Binge eating | | | |
| Bulimia | | | |
| Can't gain weight | | | |
| Can't lose weight | | | |
| Carbohydrate craving | | | |
| Carbohydrate intolerance | | | |
| Poor appetite | | | |
| Salt craving | | | |
| **DIGESTION:** | | | |
| Anal spasms | | | |
| Bad teeth | | | |
| Bleeding gums | | | |
| Bloating of: Lower abdomen | | | |
| Whole abdomen | | | |
| Blood in stools | | | |
| Burping | | | |
| Canker sores | | | |
| Cold sores | | | |
| Constipation | | | |
| Cracking at corner of lips | | | |
| Dentures w/poor chewing | | | |
| Diarrhea | | | |
| Difficulty swallowing | | | |
| Dry mouth | | | |
| Farting | | | |

| DIGESTION, Cont'd: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Fissures | | | |
| Foods "repeat" (reflux) | | | |
| Heartburn | | | |
| Hemorrhoids | | | |
| Intolerance to: Lactose | | | |
| All milk products | | | |
| Intolerance to: Gluten (wheat) | | | |
| Corn | | | |
| Eggs | | | |
| Fatty foods | | | |
| Yeast | | | |
| Liver disease/jaundice (yellow eyes or skin) | | | |
| Lower abdominal pain | | | |
| Mucus in stools | | | |
| Nausea | | | |
| Periodontal disease | | | |
| Sore tongue | | | |
| Strong stool odor | | | |
| Undigested food in stools | | | |
| Upper abdominal pain | | | |
| Vomiting | | | |
| **SKIN PROBLEMS:** | | | |
| Acne on back | | | |
| Acne on chest | | | |
| Acne on face | | | |
| Acne on shoulders | | | |
| Athlete's foot | | | |
| Bumps on back of upper arms | | | |
| Cellulite | | | |
| Dark circles under eyes | | | |
| Ears get red | | | |
| Easy bruising | | | |

# Medical History Form

| SKIN PROBLEMS, Cont'd: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Eczema | | | |
| Herpes - genital | | | |
| Hives | | | |
| Lackluster skin | | | |
| Moles w color/size change | | | |
| Oily skin | | | |
| Pale skin | | | |
| Patchy dullness | | | |
| Psoriasis | | | |
| Rash | | | |
| Red face | | | |
| Sensitive to bites | | | |
| Sensitive to poison ivy/oak | | | |
| Shingles | | | |
| Skin cancer | | | |
| Skin darkening | | | |
| Strong body odor | | | |
| Thick calluses | | | |
| Vitiligo | | | |
| **SKIN, ITCHING:** | | | |
| Anus | | | |
| Arms | | | |
| Ear canals | | | |
| Eyes | | | |
| Feet | | | |
| Hands | | | |
| Legs | | | |
| Nipples | | | |
| Nose | | | |
| Penis | | | |
| Roof of mouth | | | |
| Scalp | | | |
| Skin in general | | | |
| Throat | | | |

| SKIN, DRYNESS OF: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Eyes | | | |
| Feet | | | |
| Any cracking? | | | |
| Any peeling? | | | |
| Hair | | | |
| And unmanageable? | | | |
| Hands | | | |
| Any cracking? | | | |
| Any peeling? | | | |
| Mouth/throat | | | |
| Scalp | | | |
| Any dandruff? | | | |
| Skin in general | | | |
| **LYMPH NODES:** | | | |
| Enlarged/neck | | | |
| Tender/neck | | | |
| Other enlarged/tender lymph nodes | | | |
| **NAILS:** | | | |
| Bitten | | | |
| Brittle | | | |
| Curve up | | | |
| Frayed | | | |
| Fungus - fingers | | | |
| Fungus - toes | | | |
| Pitting | | | |
| Ragged cuticles | | | |
| Ridges | | | |
| Soft | | | |
| Thickening of: Finger nails | | | |
| Toenails | | | |
| White spots/lines | | | |

# Medical History Form

| RESPIRATORY: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Bad breath | | | |
| Bad odor in nose | | | |
| Cough - dry | | | |
| Cough - productive | | | |
| Hay fever : Spring | | | |
| Summer | | | |
| Fall | | | |
| Change of season | | | |
| Hoarseness | | | |
| Nasal stuffiness | | | |
| Nose bleeds | | | |
| Post nasal drip | | | |
| Sinus fullness | | | |
| Sinus infection | | | |
| Snoring | | | |
| Sore throat | | | |
| Wheezing | | | |
| Winter stuffiness | | | |
| **CARDIOVASCULAR:** | | | |
| Angina/chest pain | | | |
| Breathlessness | | | |
| Heart attack | | | |
| Heart murmur | | | |
| High blood pressure | | | |
| Irregular pulse | | | |
| Mitral valve prolapse | | | |
| Palpitations | | | |
| Phlebitis | | | |
| Swollen ankles/feet | | | |
| Varicose veins | | | |

| FEMALE REPRODUCTIVE, Cont'd: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Premenstrual:<br>Bloating | | | |

| URINARY: | Mild | Mod-erate | Severe |
|---|---|---|---|
| Bed wetting | | | |
| Hesitancy | | | |
| Infection | | | |
| Kidney disease | | | |
| Kidney stone | | | |
| Leaking/incontinence | | | |
| Pain/burning | | | |
| Prostate enlargement | | | |
| Prostate infection | | | |
| Urgency | | | |
| **FEMALE REPRODUCTIVE:** | | | |
| Breast cysts | | | |
| Breast lumps | | | |
| Breast tenderness | | | |
| Ovarian cyst | | | |
| Poor libido (sex drive) | | | |
| Endometriosis | | | |
| Fibroids | | | |
| Infertility | | | |
| Vaginal discharge | | | |
| Vaginal odor | | | |
| Vaginal itch | | | |
| Vaginal pain | | | |

# Medical History Form

| | | | |
|---|---|---|---|
| Breast tenderness | | | |
| Carbohydrate craving | | | |
| Chocolate craving | | | |
| Constipation | | | |
| Decreased sleep | | | |
| Diarrhea | | | |
| Fatigue | | | |
| Increased sleep | | | |
| Irritability | | | |
| Menstrual: Cramps | | | |
| Heavy periods | | | |
| Irregular periods | | | |
| No periods | | | |
| Scanty periods | | | |
| Spotting between | | | |

# Medical History Form

## FAMILY HISTORY

For each member of your family, follow the line across the page and check the boxes for: 1) Their present state of health, and 2) Any illnesses they have had. *(Note: Except for spouse, Family refers to blood or natural relatives.)*

| **Name** | **Good Health** | **Poor Health** | **Decreased** | Write in age and cause of death. Include accidents and suicides. |
|---|---|---|---|---|
| Father: | | | | |
| Mother: | | | | |
| Brothers/Sisters: | | | | |
| | | | | |
| | | | | |
| | | | | |
| Child(ren): | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| **Name** | **Alcoholism** | **Allergies or Asthma** | **Alzheimer's or Dementia** | **Anemia** | **Blood Clotting Problems** | **Diabetes** | **Cancer or Tumor** | **Epilepsy** | **Genetic Disease** | **Hearth Trouble** | **High Blood Pressure** | **Kidney or Bladder Dis.** | **Nervous Breakdown** | **Rheumatism or Arthritis** | **Stomach or Duodenal Ulcer** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Father: | | | | | | | | | | | | | | | |
| Mother: | | | | | | | | | | | | | | | |
| Brothers/Sisters: | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Child(ren): | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| **Paternal relatives** (in each box, write in how many affected with condition): | | | | | | | | | | | | | | | |
| **Maternal relatives** (in each box, write in how many affected with condition): | | | | | | | | | | | | | | | |

# Medical History Form

## READINESS ASSESSMENT

RATE ON A SCALE OF : 5= VERY WILLING TO 1= NOT WILLING (circle your answer)

In order to improve your health how willing are you to:

a) Significantly modify your diet 5 4 3 2 1
b) Have acupuncture therapy 5 4 3 2 1
c) Take several nutritional supplements each day 5 4 3 2 1
d) Take a herbal supplement 5 4 3 2 1
e) Use bio-identical hormone therapy 5 4 3 2 1
f) Keep a record of everything you eat each day 5 4 3 2 1
g) Modify your lifestyle (e.g. work demands, sleep habits, alcohol intake, etc) 5 4 3 2 1
h) Practice a relaxation technique 5 4 3 2 1
i) Engage in regular exercise 5 4 3 2 1
j) Have periodic lab test to assess your progress 5 4 3 2 1

Comments ___________________________________________________________________________

## 3 DAY DIET DIARY

**Instructions for Completing the Diet Diary**

It is important to keep an accurate record of your usual food and beverage intake as a part of this study. Please complete this 3 Day Diet Diary for three consecutive days with one day being a weekend day.

- Record information as soon as possible after the food has been consumed.
- Do not change your eating behavior at this time unless your doctor advises you to. The purpose of this food record is to analyze your present eating habits.
- Describe the food or beverage consumed. e.g., milk - what kind? (whole, 2%, or nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
- Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon sugar, potato with 2 teaspoons butter, etc.
- Please record all beverages, including water. List them in the “Beverage” category.

## DIET DIARY

**Name ____________________________ Date _________________**

**Time Food Amount Time Beverage Amount**