Health History Summary

Date_____

Name_____ Age_____ Birthdate_____ Blood type_____

Address_____ City_____ State____ Zip_____

Phone(home)_____ (work)_____daytime or eve?

Occupation_____ (full/part time?) Employer_____

Insurance Co._____Policy #_____ Soc Sec #_____

Address _____City_____ State_____ Zip_____

Nearest Relative_____ Phone_____
what is their relationship to you

Who else can we reach in case of emergency?_____ Phone_____
what is their relationship to you

How did you hear about the Tabor Hill Clinic?_____

Last physician or health practitioner seen?_____ When?_____

When was your last blood test?_____ What kind?_____

Your Current Health Problems

What is your **main** reason for coming in today? If you have a specific health condition please describe in detail. When was the very first time that you noticed your condition and describe carefully any factors that you suspect may have played a role in its onset and its continuation.

List in order of importance other health problems that are troubling you:

1)_____ & length of time_____

2)_____ & length of time_____

3)_____ & length of time_____

4)_____ & length of time_____

Other problems:_____

How long has your **main** problem been troubling you?_____

Is your current "main problem" getting *[better, worse, same]* and for how long?_____

What kind of treatment have you received and from whom?_____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for your current problem? ***(yes or no)*** or for any problem? ***(yes or no).***

What was the therapy and what were the results?_____

_____

Your Health History

The general state of your health is: **(excellent___) (good___) (avg___) (fair___) (poor___),** and on the average describe your energy level from 1-10 (10 is highest & 1 lowest) "_____"

When during the day is your energy the best?_____ worst?_____

What is your current approximate weight?_____ height?_____ Weight one year ago_____

As an adult what has been your maximum_____ and minumum weight_____ (do not include pregnancy)

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? ***(yes or no) Please circle***

1) _____date_____

2) _____ date_____

3) _____ date_____

4)_____ date_____

5)_____ date_____

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist?_____ Have you in the past?_____ If so when?(give dates)_____

Are you currently working with a Doctor of conventional medicine?(M.D. or D.O.)***(Yes or No)***

What childhood illnesses have you had? (check off if had)

measles _____	mumps_____	chickenpox_____	whooping cough____
polio _____	diphtheria_____	rheumatic fever_____	scarlet fever_____
smallpox_____	typhoid fever_____	tuberculosis_____	mono___ how long__

Previous surgeries and hospitalizations (include dates)_____

_____

Which of the following have you had and indicate "now or past";.& also how often and when.

now or past	year	now or past	year	now or past	year
____pneumonia	_____	____diabetes	_____	_____gonorrhea	_____
____tonsillitis	_____	____asthma	_____	_____syphilis	_____
____ear infections	_____	____eczema	_____	_____venereal disease	____
____chronic infections	_____	____heart disease	____	_____epilepsy	_____
____canker sores	_____	____herpes	_____	_____high blood pressure	____
____allergies	_____	____hepatitis	_____	_____mononucleosis	____
____thyroid problems	_____	____weight prob.	____	_____anemia	_____
____others	_____				

Do you have any allergies to any drugs, herbs, foods, animals or other? ***(Y or N)*** What? _____

_____

Which of the following do you currently use?

amount (how often, how much & how long) amount (how often, how much & how long)

alcohol_____ tobacco_____

hormones

_____ coffee_____

_

cortisone

_____ laxatives_____

_

sedatives _____ antacids_____

other medications (please give full name and doseage and how long have you been taking the medication) _____/ _____/

_____ _____/ _____/

_____ _____/ _____/

_____

vitamins\herbs_____/ _____/_____/_____

_____/ _____/ _____/ _____/ _____

_____/ _____/ _____/ _____/ _____

Family History

Please list ages, health problems and if deceased, cause of death:

	Living(age?)	Health Problems	Died (age?)	Cause
Your Mother	_____	_____	____	_____
Your Father	_____	_____	____	_____
Your Brothers	_____	_____	____	_____
	_____	_____	____	_____
	_____	_____	____	_____

Your Sisters _____ _____ ____ _____

_____ _____ ____ _____

_____ _____ ____ _____

Grandmom & granddad

Mother's Mom _____ _____ ____ _____

Mother's Dad _____ _____ ____ _____

Grandmom & granddad

Father's Mom _____ _____ ____ _____

Father's Dad _____ _____ ____ _____

What is your nationality? *(please list all backrounds & give approximate%)*_____

_____

You currently live with? spouse___ partner___ parents___ friends___ children___ alone____

Are you? married____ separated___ divorced___ widowed___ single___ in a supportive relationship___

What is your current level of education?_____ Are you satisfied with this? ***(Yes or No)***

Do you have any children?_____ How many? _____ Ever have Toxemia during preg. **(Y or N)**

Do they have any health problems?_____

Do you have any blood relative aunt uncle or grandparent who has had any of the following?

____allergies ____arthritis____asthma ____cancer ____diabetes

____anemia ____depression ____skin disease ____heart attack ____genetic prob

____High B.P. ____stroke ____ulcers ____cataracts ____thyroid prob

____hypoglycemia____seizures ____sickle cells ____venereal disease

What is your weakest organ system and why?_____

Personal Habits

What do you enjoy most in your life?_____

What are your main interests or hobbies?_____

What do you worry most about in life?_____

Do you exercise? ***(yes/no)*** If yes what kind, how much & how often?_____

Do you have a religious or spirtual practice? (***Yes/No***) If yes, what?_____

On a scale of 1-10, how would you rate the quality of your sleep (10 being great) _____

Do you have problems (*falling or staying asleep)*? ____ How many hrs do you sleep at night?____

Do you awaken at night? ***(yes or no)*** If yes what time(s) do you usually wake up?_____

Do you ever sweat at night while sleeping? ***(yes or no)***. How frequently and how much do you sweat?_____ Do you wake up feeling refreshed? ***(yes or no)***

Do you nap or rest horizontally throughout the day? ***(yes or no)***. For how long? _____

What do you normally feel like temperature wise, compared to others? ***(warm or cooler or avg)***

What are the temperatures of your hands and feet generally? **(*warmer or cooler or average)***

Do you enjoy your work? **(*yes or no)*** Do you take vacations? **(*yes or no*)**

Are you currently in a happy satisfying relationship with someone? ***(Very, mostly, somewhat, not)***

How often do you get colds, flus, sore throat, yeast infections during the year?_____

When you rise quickly from a sitting or lying position do you ever get dizzy? ***(yes or no)*** *If yes how often?****(daily; few times per week; 1x week; 2x per month; 1x per month; rarely)***

Female reproduction

Age of first menses_____ If periods have stopped at what age did they stop?_____

Are your cycles regular ***(Y N)*** Period begins every _____ days. How long periods?_____

Are your periods ***(Heavy, medium, light)*** & what color is blood?**(*light red, dark red, medium, clots*)**

Do you have any spotting or bleeding between periods ***(Y / N)*** Any cramps with period ***(Y / N)***

Do you have any premenstrual symptoms ?***(water retention, breast tenderness, irritability, depression, headaches, mood swings, food cravings)*** other _____

Number of pregnancies_____ Number of abortions_____ Number of live births?_____

Number of miscarriages_____ Any problems gettting pregnant?_____

Do you get yearly PAP smears*?****(Y /N)*** Any abnormal PAP's? ***(Y / N)*** Breast lumps?***(Y / N)***

Are you currently sexually active?***(Y N)*** How often?_____ Is this ***(more or less)*** than 1 yr ago?

Do you use birth control? ***(Y / N)*** What type of birth control do you currently use?_____

Have you ever been physically or sexually abused? ***(Y/N)*** How old and how often?_____

Male Reproduction

How often do you have to get up at night to urinate?____ Is this an increase in past few yrs*?****(Y/N)***

Any problems with impotency? (getting or maintaining an erection) ***(Y/N).*** Any sores on penis? ***(Y/N).***

Do you have any abnormal discharge from the penis? ***(Y/N)*** Any veneral diseases? **(*yes or no)***

Any prostate problems? **(Y/N & *past/now)*** Ever have your prostate examined?(Y/N). When?_____

Are you currently sexually active?***(Y/N)*** How often?_____ Is this ***(more or less)*** than 1 yr ago?

Do you use birth control? ***(Y or N)*** What type of birth control do you currently use?_____

Have you ever been physically or sexually abused? ***(Y/N)*** How old and how often?_____

Digestion and Elimination

Digestion *(circle or fill in the answer)*

Do you have any problems with gas, bloating or fullness after eating? (**Yor N**). How often do you have gas, fullness or bloating after eating? ***(often, sometimes, never)***. How severe?_____
Do you have gas in ***(the upper part of the abdomen or lower part or both areas)***?

How long have you had this problem?_____

How often do you have bowel movements?_____

Do you ever have any **(blood, mucus, undigested food, black stools)**?

Any rectal itching? **(Y/N)** Do your stools tend to be ***(formed or loose)***? How often do you have diarrhea?_____Do you ever have alternating constipation and diarrhea? **(Y N)**

How often do you have thin, long and narrow stools? ***(often sometimes never)***

How often do you have small & hard stools?***(often, sometimes, never)***

Do you ever have yellow or light colored stools? **(*often, sometimes, never)***

How often do your stools have a strong disagreeable odor? ***(often, sometimes, never)***

Have you ever fasted? ***(yes or no; juice or water)*** For how long have you fasted?_____

How did you feel while you were fasting?_____

Have you traveled outside the U.S. in last 5 years? ***(Y/N)*** *Have you gone camping in last 5 yrs?****(Y/N)***

Kidneys and bladder

Have you had recurrent bladder infections?***(Yes or No)*** How were they treated?_____

How many bladder infections have you had in the last 3 years?_____

Do you have any burning sensation during or after urination? ***(Past or Present or now)***

Is your urine ***(dark yellow, bright yellow, cloudy, pale or clear)****?*

Does your urine have a strong odor to it? ***(Yes or No)***

Do you have difficulty starting or stopping when urinating? ***(Yes or No)***

Do you have difficulty perspiring? ***(Y N)***.. Do you perspire when you exercise? ***(lightly, moderately, heavily)***. Do you perspire other times than when exercising? ***(Y N)*** When?

Does your perspiration have a strong smell? ***(Yes or No)***

Does your temperature tend to run ***(low or high or average)***compared to others*?(circle one)*

Occupational/household

How long have you lived at your present address?_____ Where have you lived previously? _____***(Please describe location, if old or new place, i.e., new construction, damp or moldy)***

Do you have specialized air filtration at home? ***(yes or no)*** *Do you live in city?* ***(Yes or No)***

Do you work in an office building? ***(yes or no)*** Do the windows open? ***(yes or no)***

Do you have specialized air filtration at your work place? ***(yes or no)***

Do you work in the presence of toxic fumes or chemicals? ***(yes or no)***

Do any of your hobbies involve toxic materials? ***(yes or no)***

Are you exposed to second hand smoke currently? ***(yes or no)***

What do you use for your drinking water? ***(bottled, filtered, or tap water)***

Do you have anything else you would like to comment on? _____