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**Opinions about Your Health**

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How does your condition affect you?

What do you think is happening; why do you think you have this condition?

What do you feel needs to happen for you to get better?

How much change are you willing to make at this time for improving your health?

circle one:    MINIMAL    SOME    COMPLETE

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**Allergies**

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To any drugs?

To any foods?

To any environmental pollens/grasses?

Other?

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**Past Medical History**

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**Surgeries:** List the type and year of any surgeries:

**Hospitalizations:** List any other hospitalizations and the reason:

List all the **medications** that you are currently taking, including dosages:

List all **vitamins, minerals, herbs, homeopathic remedies and nutritional supplements** you are currently taking:

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**Personal Habits**

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Do you eat three meals per day? Y N

Do you wake feeling rested? Y N

Do you have a supportive relationship? Y N

Have you had any major traumas? Y N

Do you have a history of abuse? Y N (physical, emotional or sexual)

Do you drink coffee? Y N

Do you drink sodas or energy drinks? Y N

Do you consume alcohol? Y N (Beer Wine Spirits)

Number of drinks per day/week/month \_\_\_\_\_

Do you smoke? Y N Current or Past Yr started \_\_\_\_\_ Yr stopped \_\_\_\_\_

Do you now or have you ever used recreational drugs? Y N

Religious or spiritual practice? Y N Do you enjoy your job? Y N

Do you watch TV? Y N hrs per week \_\_\_\_\_ Do you read? Y N hrs per week \_\_\_\_\_

**Sleep**

Usual bedtime \_\_\_\_\_ Hours slept \_\_\_\_\_

Problems with falling asleep or waking up after your fall asleep: Y N

Dreams and/or nightmares: Y N

**Energy Level** when waking up, throughout the day. (1 = low, 10 = high)

1 2 3 4 5 6 7 8 9 10

**Exercise**

How often do you exercise and what type of exercise?

Do you experience any symptoms during exercise (pain in any particular place in your body, shortness of breath, extreme fatigue beyond what is normal for the activity, heart palpitations, dizziness, abnormally high or low perspiration, etc.)?

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**Current Health Status and History**

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What is your blood type? \_\_\_\_\_

Weight \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_

Maximum Weight \_\_\_\_\_ when?

What do you think should be your desired weight \_\_\_\_\_ Height \_\_\_\_\_

**Please circle any of the following conditions/symptoms you have had, Yes-I have this now; Never-I've never had it; Past-I've had it in the past but not now.**

**Head**

Headaches	Y	N	P	Migraines	Y	N	P
Lightheadedness	Y	N	P	Dizziness	Y	N	P
Bell's Palsy	Y	N	P	Head injury or trauma	Y	N	P
Concussion	Y	N	P	Loss of balance	Y	N	P

Jaw/TMJ problems                    Y   N   P    Other? \_\_\_\_\_

**Eyes**

Spots in eyes	Y	N	P	Impaired vision	Y	N	P
Blurriness	Y	N	P	Color blindness	Y	N	P
Double vision	Y	N	P	Eye pain	Y	N	P
Swollen eyes	Y	N	P	Eyestrain	Y	N	P
Cataracts	Y	N	P	Glasses/contacts	Y	N	P
Tearing or dryness	Y	N	P	Glaucoma	Y	N	P
Night blindness	Y	N	P	Circles under eyes	Y	N	P
Other _____							

**Ears**

Impaired hearing	Y	N	P	Deafness	Y	N	P
Earaches	Y	N	P	Itching of ears	Y	N	P
Ringing in ears	Y	N	P	Excessive ear wax	Y	N	P
Frequent ear infections	Y	N	P				
Other? _____							

**Nose & Sinuses**

Frequent colds	Y	N	P	Stiffness	Y	N	P
Post nasal drips	Y	N	P	Loss of Smell	Y	N	P
Nose bleeds	Y	N	P	Sinus Problems	Y	N	P
Hayfever	Y	N	P	Allergies	Y	N	P
Polyps	Y	N	P	Other? _____			

**Mouth & Throat**

Frequent sore throat	Y	N	P	Sores in mouth	Y	N	P
Hoarseness	Y	N	P	Difficulty swallowing	Y	N	P
Loss of taste	Y	N	P	Teeth grinding	Y	N	P
Sore lips	Y	N	P	Enlarged lymph nodes	Y	N	P
Sore tongue	Y	N	P	Gum problems	Y	N	P
Dental problems	Y	N	P	Difficulty speaking	Y	N	P
Dental cavities	Y	N	P	Jaw clicks	Y	N	P
Copious saliva	Y	N	P	Dry mouth	Y	N	P
Other? _____							

**Respiratory**

Coughing	Y	N	P	Spitting up blood	Y	N	P
Wheezing	Y	N	P	Difficulty breathing	Y	N	P
Pain with breathing	Y	N	P				
Shortness of breath	Y	N	P	while lying down?    at night?			
Sputum	Y	N	P	Bronchitis	Y	N	P
Pleurisy	Y	N	P	Emphysema	Y	N	P
Pneumonia	Y	N	P	Asthma	Y	N	P
Positive TB Test	Y	N	P	Other? _____			

**Cardiovascular**

Heart disease	Y	N	P	High/Low blood pressure	Y	N	P
Blood Clots	Y	N	P	Phlebitis	Y	N	P
Rheumatic Fever	Y	N	P	Swelling in ankles	Y	N	P
Bleeding/clotting disorder	Y	N	P	High cholesterol	Y	N	P
Atherosclerosis	Y	N	P	Angina	Y	N	P
Heart murmurs	Y	N	P	Fainting	Y	N	P

Palpitations	Y	N	P	Heart Flutters	Y	N	P
Chest Pain	Y	N	P	Stroke	Y	N	P
Heart attack	Y	N	P	Other? _____			

**Circulation**

Cold hands/feet	Y	N	P	Deep leg pain	Y	N	P
Easy bleeding/bruising	Y	N	P	Varicose veins	Y	N	P
Thrombophlebitis	Y	N	P	Other? _____			

**Gastrointestinal**

Trouble swallowing	Y	N	P	Jaundice	Y	N	P
Nausea	Y	N	P	Vomiting blood	Y	N	P
Blood in stool	Y	N	P	Abdominal pain/cramps	Y	N	P
Belching or passing gas	Y	N	P	Gallbladder disease	Y	N	P
Ulcers	Y	N	P	Liver disease	Y	N	P
Hepatitis	Y	N	P	Heartburn	Y	N	P
Acid Reflux	Y	N	P	Change in appetite	Y	N	P
Diarrhea	Y	N	P	Constipation	Y	N	P
Bloating	Y	N	P	Stomach pain	Y	N	P
Black Stools	Y	N	P	Diverticulitis/losis	Y	N	P
Crohn's disease	Y	N	P	Irritable Bowel Syndrome	Y	N	P
Hemorrhoids	Y	N	P	Change in thirst	Y	N	P
Colitis	Y	N	P	Hiatal Hernia	Y	N	P
Vomiting	Y	N	P	Other? _____			

Frequency of bowel movements (number per day) \_\_\_\_\_

Quality of stools (small and hard, loose, etc.) \_\_\_\_\_

**Urinary**

Pain during urination	Y	N	P	Frequency at night	Y	N	P
Bladder infections	Y	N	P	Unable to urinate	Y	N	P
Increased frequency	Y	N	P	Unable to hold urine	Y	N	P
Kidney stones	Y	N	P	Blood in urine	Y	N	P

Other? \_\_\_\_\_

Approximate number of times you urinate per day \_\_\_\_\_

Waking up at night to urinate: Y N Pain or other symptoms during urination, etc. Y N

**Skin**

Rashes	Y	N	P	Hives	Y	N	P
Acne, boils	Y	N	P	Moles	Y	N	P
Lumps	Y	N	P	Ulceration	Y	N	P
Shingles	Y	N	P	High cholesterol	Y	N	P
Atherosclerosis	Y	N	P	Eczema	Y	N	P
Psoriasis	Y	N	P	Itching	Y	N	P
Dryness	Y	N	P	Perpetual hair loss	Y	N	P
Night sweats	Y	N	P	Sores	Y	N	P
Infections	Y	N	P	Change in hair/nails	Y	N	P

Other? \_\_\_\_\_

**Neck**

Pain or stiffness	Y	N	P	Swollen Glands	Y	N	P
Pinched nerve	Y	N	P	Lumps	Y	N	P
Herniated disk	Y	N	P	Other? _____			

**Musculoskeletal**

Joint pain or stiffness	Y	N	P	Muscle spasms	Y	N	P
Muscle weakness	Y	N	P	Arthritis	Y	N	P
Bursitis	Y	N	P	Osteoporosis	Y	N	P
Osteopenia	Y	N	P	Broken Bones	Y	N	P
Back Pain	Y	N	P	Herniated disk	Y	N	P
Back surgery	Y	N	P	Other? _____			

**Neurological**

Seizures	Y	N	P	Muscle weakness	Y	N	P
Loss of memory	Y	N	P	Vertigo	Y	N	P
Dizziness	Y	N	P	Trembling hands/feet	Y	N	P
Mood swings	Y	N	P	Epilepsy	Y	N	P
Paralysis	Y	N	P	Numbness or tingling	Y	N	P
Loss of balance	Y	N	P	Lightheaded	Y	N	P
Poor concentration	Y	N	P	Slurred speech	Y	N	P
Neuralgia	Y	N	P	Loss of coordination	Y	N	P
Easily stressed	Y	N	P	Other? _____			

**Mental / Emotional**

Excess Stress	Y	N	P	Anxiety	Y	N	P
Panic Attacks	Y	N	P	Depression	Y	N	P
Mood swings	Y	N	P	Memory loss	Y	N	P
Suicidal thoughts	Y	N	P	Treated for emotions	Y	N	P
Nervousness	Y	N	P	Seasonal depression	Y	N	P
Other? _____							

**Endocrine**

Hypothyroid	Y	N	P	Hyperthyroid	Y	N	P
Hypoglycemia	Y	N	P	Excessive thirst	Y	N	P
Unexplained weight loss	Y	N	P	Fatigue	Y	N	P
Hormonal problems	Y	N	P	Heat or cold intolerance	Y	N	P
Diabetes	Y	N	P	Excessive hunger	Y	N	P
Seasonal depression	Y	N	P	Easy weight gain	Y	N	P
Pituitary disorder	Y	N	P	Adrenal problem	Y	N	P
Other? _____							

**Immune**

Slow wound healing	Y	N	P	Chronic fatigue syndrome	Y	N	P
Chronic swollen glands	Y	N	P	Reaction to vaccinations	Y	N	P
Chronic infections	Y	N	P	Cancer	Y	N	P
Other? _____							

**Infectious Illnesses**

Scarlet Fever	Y	N	P	Tick bite	Y	N	P
Diphtheria	Y	N	P	Rheumatic Fever	Y	N	P
Chicken Pox	Y	N	P	German Measles	Y	N	P
Mumps	Y	N	P	Measles	Y	N	P
Polio	Y	N	P	Meningitis	Y	N	P
Epstein-Barr	Y	N	P				
Other? _____							

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**Male Reproductive System History**

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**Male Genitourinary**

Urinary Frequency	Y	N	P	Urging without passing urine	Y	N	P
Waking during night to urinate	Y	N	P	Pain/burning	Y	N	P
Trouble starting urine	Y	N	P	Cloudy urine	Y	N	P
Red-tinged/blood urine	Y	N	P	Foul-smelling urine	Y	N	P
Prostate Cancer	Y	N	P	BPH	Y	N	P
Testicular cancer	Y	N	P	Penile cancer	Y	N	P
Pain or sores on penis	Y	N	P	Discharge from penis	Y	N	P
Hernias	Y	N	P	Testicular pain	Y	N	P
Testicular swelling	Y	N	P	Lumps on testicles	Y	N	P
Inability to achieve or maintain an erection				Y	N	P	
Premature ejaculation				Y	N	P	
Surgery of prostate, genitals, hernia, vasectomy				Y	N	P	
Other? _____							

History of sexually transmitted diseases? Y N

Circle all that apply:

Herpes    Venereal Warts    Gonorrhea    Syphilis    Chlamydia    HIV/AIDS    Other

Family History of:

\_\_\_\_ Prostate Cancer    \_\_\_\_ Enlarged Prostate    \_\_\_\_ Testicular Cancer If so, who? \_\_\_\_\_

Date of your last prostate exam \_\_\_\_\_

Ever have abnormal findings on a prostate exam Y N \_\_\_\_\_

**Sexual History**

Are you currently sexually active? Y N With men, women or both? \_\_\_\_\_

Do you have multiple partners? Y N

Do you experience pain or discomfort during sex? Y N

Do you use condoms or other birth control methods? Y N \_\_\_\_\_

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**Childhood History**

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*To the best of your memory, please provide the following information*

Age of your mother when you were born: \_\_\_\_\_

Number of her previous pregnancies: \_\_\_\_\_

Indicate any medical problems your mother had while pregnant with you?

Did your mother take any medications during pregnancy?

Did she use Alcohol or Tobacco while pregnant with you or while nursing? Y N

Were you breastfed as a child and if so, how long?

Did your parents note any adverse reactions to vaccinations or illnesses around the time you received them?

During each of the following age periods, 1) where did you live, 2) what illnesses did you have?

- birth to 2 years

- 2 years to 5 years

- 5 years to puberty

- puberty through roughly age 20

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**Family Medical History**

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	<b>Mother</b>	<b>Father</b>	<b>Brothers</b>		<b>Sisters</b>		<b>Children</b>	
Age (if living)								
Cancer								
Diabetes								
Heart Trouble								
Hypertension								
Stroke								
Epilepsy								
Mental disorders								
Asthma								
Allergies								
Other conditions								
Age of Death								
Cause of Death								

