Personal Information Section

Today's Date:
Birth Date: Age:
Name: Marital Status:

Date of Last Physical Exam:

Street Address: City:
State: Zip Code: Phone:
E-mail:

Number of Children: Ages of Children:

Education Years in High School: Years College:

Post Graduate: Current Occupation:

Family History Section

Ages of Living Relatives:
Mother: Father:
Grandmother: Grandfather:
How Many Brothers: Ages of Brothers:
How Many Sisters:
Ages of Sisters:

Deceased Relatives: Age & Cause of Death:

Please indicate any family history of any of these conditions. What type?

Skin Diseases:	
Cancer:	
Arthritis:	
Tuberculosis:	
AIDS:	
Thyroid disorder:	
Diabetes:	
Pancreatitis:	
Hypoglycemia:	
Adrenal Disorder (Graves):	
Reproductive Issues:	
Heart Trouble:	
High Blood Pressure:	
Stroke:	
Epilepsy:	
Nervous Breakdowns:	
Asthma, Hives, Hay fever:	
Blood Disease:	
Kidney Disease:	
High Cholesterol:	

Personal Habits Section

Personal Enjoyments	Yes	No	Explain
Do you exercise? What do you do?			
How often?			
Do you sleep well? Average hours?			
Do you awake rested?			
Have Regular Bowel Movements?			
How often?			
Painful or Unsatisfying Sex?			
Cause?			
Do you like your work?			
Is it outdoors or indoors?			
Relaxation?			
How?			
Watch TV?			
Read?			
Take Vacations?			
How often?			
Treated for Alcohol or Drug Abuse?			

Please indicate if any of the following are taken:

Supplements/ Pleasures	Yes	No	Explain:
Laxatives? How often			
Vitamins?			
Sedatives/ Tranquilizers?			
Aspirin/ Tylenol?			
Alcoholic Beverages? Many in a week?			
Coffee / Black Tea? Many cups a day?			
Soda? Many in a week?			
Water? Many glasses a day?			
Appetite Suppressants?			
Do you smoke cigarettes? Many a day?			
Snuff/ Chew Tobacco?			
Marijuana?			
Other Recreational Drugs?			
Prescription Drugs:			

Please indicate if anything below is applicable to you:

Concern:	Yes	No	Explain:
Rheumatic fever or heart disease?			
Arthritis or Rheumatism?			
Bone or joint disease?			
Gallbladder disease?			
Been hospitalized for any illness?			
Any allergies, (food, drugs)?			

Any surgeries or operations?			
Any broken or cracked bones?			
Any dislocated bones?			
Any head injuries or concussions?			
Armed Services? When? Where?			

Symptoms Section

Please place a check mark, to indicate if you are currently showing any of these symptoms

Symptoms: Head/ Eyes	Check	When occurred
Frequent/ Severe Headaches		
Neck Pain		
Neck Lumps or Swelling		
Loss of Balance		
Dizzy Spells		
Blackouts / Fainting		
Wear Glasses		
Blurry Vision		
Eye Pains or Itching		
Watery Eyes		
Eyesight Worsening		
See Double		
See Halos or Lights		
Symptoms: Muscular	**Check**	**When occurred**
Aching Muscles or Joints		
Swollen Joints		
Back / Shoulder Pains		
Weakness in Arms & Legs		
Numbness		
Symptoms: Skin	**Check**	**When occurred**
Skin Problems		
Scalp Problems		
Symptoms: Hearing	**Check**	**When occurred**
Hearing Difficulties		
Earaches		
Ringing / Noises in Ears		
Symptoms: Dental	**Check**	**When occurred**
Sore or Bleeding Gums		
Bad Breath		
Sore Tongue		
Symptoms: Respiratory	**Check**	**When occurred**
Congested Nose		
Running Nose		
Sneezing Spells		
Head Colds		
Nose Bleeds		
Sore Throat		

Difficulty Swallowing		
Hoarse Voice		
Wheezing or Gasping for Air		
Frequent Coughing		
Cough up Phlegm		
Cough up Blood		
Chest Colds		
Symptoms: Heart & Circulatory	Check	When occurred
Rapid/ Skipped/ Slow Heart Beats		
Chest Pains		
Shortness of Breath with Normal Activity		
Swollen Feet or Ankles		
Bruise Easily		
Leg Cramps		
Painful Feet		
Legs Trembling		
Symptoms: Central Nervous	Check	When occurred
Nervousness / Anxiety		
Nervousness with Strangers		
Nail Biting		
Difficulty Making Decisions		
Poor Concentration		
Absentmindedness / Loss of Memory		
Lonely/ Depressed		
Frequent Crying		
Hopeless Outlook		
Symptoms: Digestion	Check	When occurred
Frequent Belching		
Nausea		
Vomiting		
Pain in Abdomen/ Cramps		
Bloated Abdomen		
Constipation		
Loose Bowels		
Black Stools		
Grey / Whitish Stools		
Pain in Rectum		
Itching Rectum		
Blood with Stools		
Symptoms: Urinary Tract	Check	When occurred
Frequent Urination		
Involuntary Escape of Urine		
Burning Sensation with Urination		
Brown, Black or Bloody Urine		
Weak Urine Stream		
Difficulty Starting Urine		
Constant Urge to Urinate		
Symptoms: Adrenals/ Thyroid	Check	When occurred
Loss or Gain in Weight		

Current Weight		
Weight One Year Ago		
Frequently Feel Colder or Warmer		
Symptoms: Hormonal	Check	When occurred
Loss of Appetite		
Always Hungry		
Armpits or Groin Swelling		
Unusual Fatigue or Weariness		
Difficulty Sleeping		
Fever or Chills		
Motion Sickness		
Excessive Sweating		
Night Sweats		
Hot Flashes		
Craving Sweet		
Craving Salt		
Symptoms: Emotional	Check	When occurred
Difficulty Relaxing		
Worry A lot		
Frightening Dreams or Thoughts		
Feeling of Desperation		
Shy / Sensitive		
Dislike Criticism		
Angered Easily		
Annoyed by Little Things		
Family Problems		
Problems at Work		
Sexual Difficulty		
Change in Sexual Energy		
Considered Suicide		
Sought Psychiatric Help		
Symptoms: Reproductive Men Only	Check	Comments/ Concerns:
Burning Discharge		
Lumps Swelling of Testicles		
Painful Testicles		
Vasectomy		
Prostate Inflammation		
Prostate Cancer		
Impotence		
Symptoms: Reproductive Women Only	Check	Comments/ Concerns:
Date of Last Pap/ Results P or N		
Current Form of Birth Control		
Birth Control Pills or Shots?		
How Long?		
Age of onset of Menstrual		
Regular?		
Cycle: Days Start to Start		
Flow: H, M, L		
Clots Passed?		

Pains/ Cramps?		
Date of Last Period?		
Date of Last Pelvic?		
Endometriosis?		
Fibrous Breast Tissue?		
Back Pains with Bleeding		
Vaginal Discharge/ Color/ Amount		
Pregnancy Complications?		
Yeast Infections?		
Live Births?		
Still Births?		
Miscarriages?		
Abortions?		
Premature Births?		
Cesarean Sections?		
Hysterectomy?		

In your opinion is your health good or bad?

Blood Type:

What are your major health concerns?

Diet Diary:

Please list all food, beverages, (including water), vitamins, supplements, drugs, herbs.
Note feelings, energy levels, bowel movements, or anything relevant.

Signature: ____________________________________ Today's Date: ________________________