Integrative Health History

Name_____ Date_____

Personal Health History: Check the appropriate box if you have experienced any of the following:

- ☐ Adverse reaction to medical treatment
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis or rheumatism
- ☐ Artificial heart, valve or joints
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Cancer or Tumor
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Eye Disorder
- ☐ Gout
- ☐ Headaches
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis, jaundice or Liver disorder
- ☐ Herpes
- ☐ High Blood pressure
- ☐ Immune Disorder
- ☐ Kidney Disorder
- ☐ Low Blood Pressure
- ☐ Musculo-skeletal Disorder
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Respiratory Disorder
- ☐ Rheumatic Fever
- ☐ Sciatica
- ☐ Seizures/Epilepsy
- ☐ Skin Disorders
- ☐ Special Diet
- ☐ Stomach or Intestinal Disorder
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Transfusion (before March 1985)
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary Tract Disorder
- ☐ Venereal Disease
- ☐ Other:_____

Is there anything we should know about your medical history?_____
_____

Who is your current Healthcare Provider? _____
Address_____
Phone_____ Date of Last Physical_____

What is your:
Height? _____ Usual Blood Pressure? _____
Weight? _____ Weight, 1 yr ago? _____

FAMILY HISTORY: Complete for each family member. Place X in box indicating any illnesses they ever had								
	Mother	***Father***	***Grdmother***	***Grdfather***	***Sister***	***Brother***	***Spouse***	***Children***
Allergies								
Anemia/Blood Dis								
Cancer or Tumors								
Chemical Dependency								
Diabetes								
Heart Disease								
High Blood Pressure								
Kidney or Bladder Dis								
Seizures / Epilepsy								
Stomach-Intestinal Dis								
Stroke								
Tuberculosis								
Other								
Age at Death								

Major Hospitalizations: If you have even been hospitalized for any serious medical illness or surgery, write in your most recent hospitalizations below. *Check this box ☐ if you have had more than three such hospitalizations.* (Do not include normal pregnancies).

1st Hospitalization_____
Year Operation/Illness Hospital/City/State

2nd Hospitalization _____
Year Operation/Illness Hospital/City/State

3rd Hospitalization _____
Year Operation/Illness Hospital/City/State

Medications & Supplements: Check the box next to any of the following that you are now taking.

☐ Antacids	☐ Allergy medication	☐ Sleeping pills
☐ Aspirin	☐ Ibuprofen/Advil	☐ Tranquilizers
☐ Cold tablets	☐ Laxatives	☐ Herbs
☐ Diet pills	☐ Oral Contraceptives	☐ Vitamins
☐ Diuretics	☐ Blood pressure medication	☐ Antidepressants
☐ Tylenol	☐ Prescription pain medication	☐ Hormone replacement therapy
☐ Viagra	☐ DHEA/ melatonin/ Beta HCG	☐ Yohimbine/ Yohimbe

Please list any medications that you are currently taking that are not listed above:

_____ _____ _____

_____ _____ _____

Please list any medication allergies you have:

_____ _____ _____

_____ _____ _____

Habits: Please mark any of the habits listed below which apply to you. Mark "**X**" for current habits. Mark "✓" for past habits.

Use of tobacco: ☐ Yes ☐ No If yes, # of cigarettes/day _____ age started_____

Use of alcohol: ☐ Yes ☐ No If yes, # of drinks per week _____ age started_____

Use of Caffeine: ☐ Yes ☐ No # colas / day____ # coffee / day ____ # tea / day____

Previous Pregnancies: Please fill in completely.

Year Length of Preg Labor Hours Type of Delivery Sex Weight Name

1. _____

Complications_____

2._____

Complications_____

3._____

Complications_____

What are your primary health concerns?_____
_____

Please list any secondary health concerns you may:

_____ _____

_____ _____

Tell us about your lifestyle:

What sort of diet do you have? (check one) □ Standard American □ Weight loss type
□ Fast/Quick Prep Diet □ Vegetarian □ Vegan □ Low Fat □ Low Carbs
□ Muscle Building Diet □ Balanced Food Groups □ Other_____
Is Nutrition or Diet something you'd like to improve or be evaluated for? □ Yes □ No

Are you active? (check one) □ Sedentary Job w/o exercise □ Sedentary Job w/ Much Exercise
□ Sedentary Job w/ Some Exercise □ Active Job w/o Extra Exercise □ Active Job w/ Exercise
What type of exercise do you do?_____
Would you like evaluation for the best form of exercise for your body and health? □ Yes □ No

How would you characterize your life in terms of stress?: (check one)
□ High Stress □ Much Stress □ Fairly Stressed □ Mild Stress □ Periodic Stress □ Not Stressed
Would you like to be handling stress better, or reduce the effects of stress? □ Yes □ No

Do you experience any of the following moods often? (check all that apply)
□ Depression □ Anxiety □ Insecurity □ Anger □ Irritabililty □ Phobias □ Nervousness
□ Mood Swings □ Sadness □ Short Tempered □ Obsessive Thinking □ Isolated □ Hopelessness
Would you like to be evaluated for possible treatment solutions for these states? □ Yes □ No

In which of the following areas of life are you satisfied?
□ Your work □ Your relationships □ Your family □ Your spiritual life □ Your health □ Your security