Integrative Family Practice
Blending Traditional & Alternative Solutions for Better Health
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HEALTH HISTORY

Name _____ **Date** _____

Occupation _____ **Age** _____ **Height** _____

Sex _____ **Number of Children** _____

Marital Status: □ Single □ Partner □ Married □ Separated □ Divorced □ Widow(er)

Do you have any allergies? _____ Are you pregnant? Yes _____

Reason for office visit: _____

List current health problems for which you are being treated:

_____
_____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

□ diet modification □ fasting □ vitamins/minerals □ herbs □ homeopathy □ chiropractic
□ acupuncture □ conventional drugs

other _____
_____

Do you experience any of these general symptoms EVERY DAY?

□ Debilitating fatigue
□ Chronic pain/inflammation
□ Fecal incontinence
□ Vomiting
□ Dizziness
□ Shortness of breath
□ Depression
□ Bleeding
□ Urinary incontinence
□ Diarrhea
□ Insomnia
□ Panic attacks
□ Disinterest in sex
□ Discharge
□ Low grade fever
□ Constipation
□ Nausea
□ Headaches
□ Disinterest in eating
□ Itching/rash

Current medications (prescription or over-the-counter): _____
_____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

_____

Major Hospitalizations, Surgeries, Injuries:
Please list all procedures, complications (if any) and dates:

Year Surgery	Illness, Injury	Outcome

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems):

Do you consider yourself: □underweight □overweight □just right
Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)?_____

What are your current health goals: _____

Medical History

□Arthritis □Allergies/hay fever □ Asthma
□ Alcoholism □ Alzheimer's disease □ Autoimmune disease
□ Blood pressure problems □Bronchitis □ Cancer
□ Chronic fatigue syndrome □Carpal tunnel syndrome □Cholesterol, elevated
□ Circulatory problems □ Colitis □Dental problems
□ Depression □ Diabetes □ Diverticular disease
□ Drug addiction □ Eating disorder □Epilepsy
□ Emphysema □Eyes, ears, nose, throat problems □ Environmental sensitivities
□Fibromyalgia □Food intolerance □Gastroesophageal reflux disease
□ Genetic disorder □Glaucoma □ Gout
□ Heart disease □ Infection, chronic □ Inflammatory bowel disease
□Irritable bowel syndrome □Kidney or bladder disease □ Learning disabilities
□Liver or gallbladder disease (stones) □Mental illness □Mental retardation
□ Migraine headaches □ Neurological problems (Parkinson's, paralysis) □Sinus problems
□ Stroke □ Thyroid trouble □ Obesity
□Osteoporosis □Pneumonia □Sexually transmitted disease
□Seasonal affective disorder □ Skin problems □ Tuberculosis

□Ulcer □ Urinary tract infection □Varicose veins

Other _____

Medical (Men)

□ Benign prostatic hyperplasia □ Prostate cancer □ Decreased sex drive
□ Infertility □ Sexually transmitted disease

Other _____

Medical (Women)

□Menstrual irregularities □Endometriosis □Infertility
□Fibrocystic breasts □Fibroids/ovarian cysts □Premenstrual syndrome (PMS)
□Breast cancer □Pelvic inflammatory disease □Vaginal infections
□Decreased sex drive
□ Sexually transmitted disease

Other _____

Date of last GYN exam _____ Mammogram Yes___ No___
PAP Yes___ No___ Form of birth control _____
# of children _____ # of pregnancies _____
□C-section _____ Age of first period _____
Date - last menstrual cycle _____ Length of cycle _____ days
Interval of time between cycles _____k_____days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
□Surgical menopause □Menopause

Family Health History (Parents and Siblings)

□Arthritis □Asthma □ Alcoholism □Alzheimer's disease
□ Cancer □ Depression □Diabetes □Drug addiction
□Eating disorder □ Genetic disorder □ Glaucoma □ Heart disease
□Infertility □Learning disabilities □Mental illness □ Mental retardation
□Migraine headaches □ Neurological disorders (Parkinson's, paralysis) □ Obesity
□Osteoporosis □ Stroke □ Suicide

Other _____

Health Habits

□ Tobacco: Cigarettes: #/day _____ Cigars: #/day _____
□Alcohol: Wine: #glasses/d or wk _____ Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk _____ □Caffeine: Coffee: #6 oz cups/d _____
Tea: #6 oz cups/d _____ Soda w/caffeine: #cans/d _____ Other sources _____
□Water: #glasses/d _____

Exercise

□5-7 days per week □ 3-4 days per week □ 1-2 days per week
□45 minutes or more duration per workout □30-45 minutes duration per workout
□ Less than 30 minutes □ Walk - #days/wk _____
□ Run, jog, other aerobic - #days/wk _____ □Weight lift - #days/wk _____
□Stretch - #days/wk _____

□ Other _____

Nutrition & Diet

□Mixed food diet (animal and vegetable sources) □Vegetarian □Vegan
□Salt restriction □Fat restriction □Starch/carbohydrate restriction
□ The Zone Diet □ Total calorie restriction

Specific food restrictions:

□dairy □wheat □eggs
□soy □corn □all gluten

Other _____

Food Frequency

Number of servings per day:
Dark green or deep yellow/orange
Grains (unprocessed) _____
Dairy, eggs _____
Fruits (citrus, melons, etc.) _____
Vegetables _____
Beans, peas, legumes _____
Meat, poultry, fish _____

Eating Habits

□Skip meals - which ones _____
□One meal/day □ Two meals/day □Three meals/day
□Graze (small frequent meals) □ Generally eat on the run □Eat constantly whether hungry or not

Current Supplements

□Multivitamin/mineral □ Vitamin C □Vitamin E
□ EPA/DHA □ Evening Primrose/GLA □ Calcium, source _____
□Magnesium □Zinc □ Minerals, describe _____
□Friendly flora (acidophilus) □Digestive enzymes □ Amino acids
□CoQ10 □Antioxidants (e.g., lutein, resveratrol, etc.) □ Herbs
□ Homeopathy □ Protein shakes □Superfoods (e.g., bee pollen, phytonutrient blends)
□Liquid meals (Ensure)

Others _____

I Would Like To:

ENERGY - VITALITY

□Feel more vital □ Have more energy □ Have more endurance □ Be less tired after lunch
□ Sleep better □ Be free of pain □ Get less colds and flu □ Get rid of allergies
□Not be dependent on over-the counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
□ Stop using laxatives and stool softeners
□ Improve sex drive

BODY COMPOSITION

□ Loose weight □Burn more body fat □ Be stronger □ Have better muscle tone
□ Be more flexible

STRESS, MENTAL, EMOTIONAL

□ Learn how to reduce stress □ Think more clearly and be morefocused
□ Improve memory □Be less depressed □Be less moody
□ Be less indecisive □Feel more motivated

LIFE ENRICHMENT

□ Reduce my risk of degenerative disease
□ Slow down accelerated aging
□ Maintain a healthier life longer
□ Change from a “treating-illness”orientation to creating a wellness lifestyle