Health History Form

K. Bahr
cutting-edge wellness

Today's Date

Name

Age Sex Height Date of Birth

Marital Status Number of Children

◯ Single ◯ Partner ◯ Married
◯ Separated ◯ Divorced ◯ Widower

Occupation

Are you pregnant

Are you recovering from a cold or flu?

Reason for office visit:

Date began:

Practitioner Name

Practitioner Phone Number

Date of last physical exam

Laboratory Procedures Performed (e.g., stool analysis, bloof and urine chemistries, hair analysis):

Outcome

What types of therapy have you tried for this problem(s):

☐ Diet Modification ☐ Fasting ☐ Vitamins/ Minerals
☐ Herbs ☐ Homeopathy ☐ Chiropractic
☐ Acupuncture ☐ Conventional Drugs
☐ Other

List current health problems for which you are being treated:

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

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

Year	Surgery, Illness, Injury	Outcome
Year	Surgery, Illness, Injury	Outcome
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
Stress Level	○	○	○	○	○	○	○	○	○	○

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

Your weight

Do you consider yourself: ☐ underweight ☐ overweight ☐ just right

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, farmer, miner)?

Do you have any of the following:

☐ Corrective Lenses ☐ Dentures ☐ Hearing Aid

☐ Medical Devices ☐ Implants ☐ Prosthetics

☐ Other

Recent changes in your ability to:

- ☐ See
- ☐ Hear
- ☐ Taste
- ☐ Smell
- ☐ Feel hot/ cold sensations
- ☐ Move Around

Strong **like** for any of the following flavors:

- ☐ Sour
- ☐ Bitter
- ☐ Sweet
- ☐ Rich/Fatty
- ☐ Spicy/Pungent
- ☐ Salty

Strong **dislike** for any of the following flavors:

- ☐ Sour
- ☐ Bitter
- ☐ Sweet
- ☐ Rich/Fatty
- ☐ Spicy/Pungent
- ☐ Salty

Do you prefer:

- ☐ Warmth (i.e., food, drinks, weather, etc.)
- ☐ Cold (i.e., food, drinks, weather, etc.
- ☐ No Preference

Is your sleep disturbed at the same time each night? _____

If yes, what time? _____

Please select the time of day you feel the **most energy** or the **least symptoms**:

- ☐ 7 a.m. - 9 a.m.
- ☐ 9 a.m. - 11 a.m.
- ☐ 11 a.m. - 1 p.m.
- ☐ 1 p.m. - 3 p.m.
- ☐ 3 p.m. - 5 p.m.
- ☐ 5 p.m. - 7 p.m.
- ☐ 7 p.m. - 9 p.m.
- ☐ 9 p.m. - 11 p.m.
- ☐ 11 p.m. - 1 a.m.
- ☐ 1 a.m. - 3 a.m.
- ☐ 3 a.m. - 5 a.m.
- ☐ 5 a.m. - 7 a.m.

Please select the time of day you feel the **worst** or your symptoms are **aggravated**

- ☐ 7 a.m. - 9 a.m.
- ☐ 9 a.m. - 11 a.m.
- ☐ 11 a.m. - 1 p.m.
- ☐ 1 p.m. - 3 p.m.
- ☐ 3 p.m. - 5 p.m.
- ☐ 5 p.m. - 7 p.m.
- ☐ 7 p.m. - 9 p.m.
- ☐ 9 p.m. - 11 p.m.
- ☐ 11 p.m. - 1 a.m.
- ☐ 1 a.m. - 3 a.m.
- ☐ 3 a.m. - 5 a.m.
- ☐ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERY DAY?

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

Medical History

- [ ] Arthritis
- [ ] Allergies/ hay fever
- [ ] Asthma
- [ ] Alcoholism
- [ ] Alzheimer's disease
- [ ] Autoimmune disease
- [ ] Blood pressure problems
- [ ] Bronchitis
- [ ] Cancer
- [ ] Chronic fatigue 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
- [ ] Mental Illness
- [ ] Mental retardation
- [ ] Migraine headache
- [ ] Neurologic problems (Parkinson's paralysis)
- [ ] Sinus problems
- [ ] Stroke
- [ ] Thyroid trouble
- [ ] Obesity
- [ ] Osteoperosis
- [ ] Pneumonia
- [ ] Sexually transmitted disease
- [ ] Seasonal affective disorder
- [ ] Skin problems
- [ ] Tuberculosis
- [ ] Ulcer
- [ ] Urinary tract infection
- [ ] Varicose veins
- [ ] Other

Medical (Men)

- [ ] Benign prostatic hyperplasia (BPH)
- [ ] 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

Age of first period

Date of last gynecological exam

Mammogram ☐ + ☐ -- PAP ☐ + ☐ --

Form of birth control

Number of children Number of pregnancies

☐ C-section ☐ Surgical menopause ☐ Menopause

Date of last menstrual cycle Length of cycle (days) Interval of time between cycles (days)

Any recent changes in normal menstrual flow? (e.g., heavier, large clots, scanty)

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: # glass/day or week

Liquor: # ounces/day or week

Beer: #glass/day or week

☐ Caffeine

Coffee: #6 oz cups/day

Tea: #6 oz cups/day

Soda w/ caffeine: #cans/day

Other sources

☐ Water

Glasses/day

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

Activity

- [ ] Walk
- [ ] Run/jog
- [ ] Jump rope
- [ ] Weight lift
- [ ] Swim
- [ ] Box
- [ ] Yoga
- [ ] Other

Nutrition & Diet

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

Specific food restrictions:

- [ ] dairy
- [ ] wheat
- [ ] eggs
- [ ] soy
- [ ] corn
- [ ] all gluten
- [ ] Other

Food Frequency
Servings per day:

Fruits

Dark green or deep yellow/ orange vegetables

Grains (unprocessed)

Beans, peas, legumes

Dairy, eggs

Meat, poultry, fish

Eating Habits

- ☐ Skip breakfast
- ☐ One meal/ day
- ☐ Food rotation
- ☐ Generally eat on the run
- ☐ Two meals/day
- ☐ Grace (small frequent meals)
- ☐ Eat constantly whether hungry or not
- ☐ Add salt to food

Current Supplements

- ☐ Multivitamin/ mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/ DHA
- ☐ Evening Primrose/ GLA
- ☐ Calcium
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals
- ☐ Friendly Flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol, etc.)
- ☐ Herbs - teas
- ☐ Herbs - extracts
- ☐ Chinese herbs
- ☐ Ayurvedic herbs
- ☐ Homeopathy
- ☐ Bach flowers
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid Meals
- ☐ Other

Would you like to:

- ☐ Have more energy
- ☐ Be stronger
- ☐ Have more endurance
- ☐ Increase your sex drive
- ☐ Be thinner
- ☐ Be more muscular
- ☐ Improve your complexion
- ☐ Have stronger nails
- ☐ Have healthier hair
- ☐ Be less moody
- ☐ Be less depressed
- ☐ Be less indecisive
- ☐ Feel more motivated
- ☐ Be more organized
- ☐ Think more clearly and more focused
- ☐ Improve memory
- ☐ Do better on tests in school
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ☐ Stop using laxatives or stool softeners
- ☐ Be free of pain
- ☐ Sleep better
- ☐ Have agreeable breath
- ☐ Have agreeable body odor
- ☐ Have stronger teeth
- ☐ Get less colds and flus
- ☐ Get rid of your allergies
- ☐ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)